South African Medical Journal
Suid-Afrikaanse Tydskrif vir Geneeskunde

P.O. Box 643, Cape Town Posbus 643, Kaapstad

Cape Town, 28 July 1956
Weekly 2s. 6d.

Vol. 30 No. 30

Kaapstad, 28 Julie 1956
Weekliks 2s. 6d.

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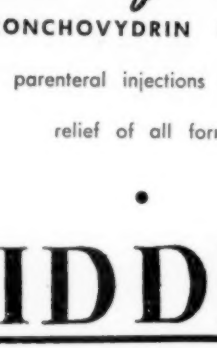

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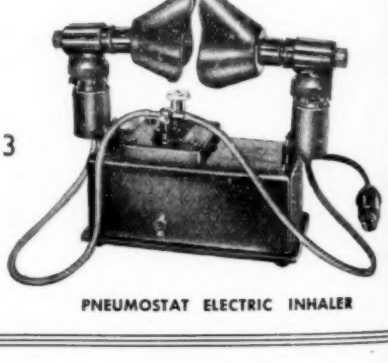

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P.O. Box 643, Cape Town — Posbus 643, Kaapstad

Cape Town, 28 July 1956 — Weekly 2s. 6d. — Vol. 30 No. 30 — Kaapstad, 28 Julie 1956 — Weekliks 2s. 6d.

EDITORIAL

THE WAY TO A MAN'S HEART

There is evidence, not yet amounting to proof, that patients suffering from coronary-artery disease may benefit from the application of certain dietary principles. Two theories have been propounded. The earlier theory is that excess of any kind of fat in the diet is liable to lead to atheroma; the later one draws a distinction between saturated and unsaturated fats and is based on certain observations that the ingestion of highly unsaturated fats does not lead to a rise in serum-cholesterol and may even neutralize the tendency of saturated fats to do so. (Animal fats on the whole contain a lower proportion of unsaturated fats, and vegetable fats and those from fishes and marine mammals a higher proportion of unsaturated fats.) These theories are based on evidence but, let it again be said the evidence does not amount to proof and the two theories have yet to be reconciled. Nevertheless, coronary patients may, not unreasonably, wish to avail themselves of advice based on these theories even before final proof is achieved. How, then, can we as doctors advise them according to these theories on the composition of the diet and the best method of its preparation?

On the first theory, viz. that fat of *any* kind should be limited, the recommended diet is very conducive to weight reduction. Since overweight is probably also undesirable the restricted fat-intake serves a double purpose, provided excessive carbohydrates in the form of rice, bread, sugar, sweets, honey, syrup, and 'cool drinks' are not substituted. The diet includes all fresh fruits and vegetables with the exception of avocado pear. It contains bread, cereals, jams, tea and coffee. Egg white but not the yolk may be eaten. Lean meat and fish form the basis of the diet and are allowed freely. Mutton, being usually very fatty, is best avoided, with the exception of the inner portion of the leg. In pork the fat is so inextricably mixed

VAN DIE REDAKSIE

DIE WEG NA 'N MAN SE HART

Die resultate van sekere proefnemings dui daarop dat pasiënte wat aan kroonslagaarsiekte ly baat sal vind by sekere dieetbepalings, maar hierdie feite kan nog nie as afdoende bewys volstaan nie. Twee toerieë is voorgelê. Die eerste een is dat 'n oormaat van enige soort vet in die dieet na slagaarvervetting kan lei; die jongste teorie onderskei tussen die versadigde en die onversadigde vette en is gebaseer op sekere waarnemings, nl. dat die inname van hoogs onversadigde vette nie die serum-cholesterolstand van die bloed laat styg nie en dat dit moontlik selfs die neiging van die versadigde vette om die cholesterolstand te verhoog kan teenwerk. (In die algemeen bevat die dierevette na verhouding min onversadigde vette, terwyl die vette van plante, vis en see-soogdiere 'n groter proporsie onversadigde vette bevat.) Hierdie teories is op feite gebaseer, maar dit moet goed verstaan word dat hierdie feite nog nie afdoende bewys is nie, en die twee toerieë moet tewens ook nog met mekaar versoen word. Dit is egter verstaanbaar dat kroonslagaar-pasiënte gebruik sal wil maak van dieetkundige raadgewings gebaseer op hierdie stellings nog voordat 'n finale beslissing bereik word. Watter raad kan ons as geneeshere hulle gee oor die samestelling van hul dieet en die beste manier om hul kos voor te berei?

Uit die aard van die saak is 'n dieet gebaseer op die eerste teorie, nl. dat *alle* soorte vette beperk moet word, baie verslankend. Aangesien oorgewig klaarblyklik op sigself ongewens is, sal 'n beperkte vet-inname 'n tweeledige diens bewys, mits die vette dan nie vervang word met te veel koolhidrate soos rys, brood, suiker, lekkergoed, heuning, stroop en koeldranke nie. Die dieet sluit alle vars vrugte en groente, behalwe avokadopere, in. Brood, graankos, konfyt, tee en koffie word toegelaat. Die wit van eiers mag geëet word, maar nie die eierdooier nie. Vis en maer vleis vorm die grondslag van die dieet en word ruimskoots toegelaat. Skaapvleis is gewoonlik baie ryk aan vet en moet liefs vermy word; die binneste gedeelte van die boud mag egter gebruik word. By varkvleis is die vleisvesels so onafskeidbaar ‚deurspek' dat die vet nie verwyder kan word nie, en varkvleis word dus nie toegelaat nie.

with the meat fibres that it cannot be removed and so pork is not permitted. Veal is low in fat and so is the white meat (breast) of chicken. The cheaper grades of beef, albeit a bit tougher, contain much less fat. Some fish are more fatty than others. Mackerel, herring, haarders and snoek are all very fatty. Stockfish, kingklip and crayfish are all relatively poor in fat. Condiments not containing fat are all allowed, including salt, pepper, mustard, tomato sauce, pickles and Worcester sauce. Alcohol is not indicted. Chestnuts are the only nuts which are fat-free. Whole-milk products (milk, cream, butter, cheese, ice cream) cannot be allowed except in minimal amounts, but skim milk and cottage cheese may be allowed. All varieties of pastries, pies and puddings containing any of these products or their substitutes (e.g. margarine, vegetable fats) must be indicted, and so must chocolates, toffee and fudge.

Is this the end of all tasty cooking? Can one possibly cook without the use of fat? It is not easy but it can be done. There cannot be a great deal of variety and the cook must develop skill in the preparation of sauces such as those consisting of tomato, onion, mushroom, condiments, meat extracts, vegetable extracts and gravy powders. Meat and fish must be grilled or boiled, not fried or roasted, though it may be roasted in a double roaster, which avoids the use of fat entirely, and the gravy can be removed before serving. All obvious fat must be removed. Casserole dishes can be cooked without the use of fat. Soups and stews can be prepared the day before, chilled overnight and the layer of fat which collects on the surface can be skimmed. Vegetables may be eaten either raw, boiled or grilled. Slightly undercooked pressure-cooked vegetables can be very tasty.

The composition of commercially prepared foods should be looked into. Tinned soups may contain cream; prepared puddings and stews may have large amounts of fat. If in doubt it is a good idea to write to the manufacturer.

The second theory, tending to exonerate unsaturated fats, which are present in vegetable and marine oils, is based on very recent experimental work. Such oils are contained in wheat and maize germ and this may be a reason for preferring brown or whole-meal bread to white. Similarly oats or mealie meal may be better than foods from which the oils have been removed in processing, e.g. certain commonly used breakfast cereals. More important, this theory may permit the use of certain cooking oils, which are commonly blends of sunflower-seed oil, maize oil, cottonseed oil and peanut oil. The more expensive brands usually contain more of peanut oil, which is not quite so unsaturated as the others. Hardened or hydrogenated fats are saturated, and even if made from Kalfsvleis, en die wit hoendervleis (borsgedeelte) is arm aan vet. Die goedkoop grade beesvleis is nou wel 'n bietjie taai, maar bevat baie minder vet. Party vissoorte bevat meer vet as ander. Makriel, haring, haarders en snoek bevat almal baie vet. Stokvis, koningklipvis en kreef bevat betrelik min vet. Genot- of geurmiddels wat geen vet bevat nie word toegelaat—sout, peper, mosterd, tamatiesous, atjar en surigheidjies, en Worcester-sous. Alkohol mag gebruik word. Kastaiings is die enigste neute wat nie vet bevat nie. Volmelkprodukte (melk, room, botter, kaas, roomys) kan slegs in baie klein hoeveelhede toegelaat word, maar afgeroomde melk en ondermelkkaas mag gebruik word. Alle soorte gebak, pasteie en poedings, sjokolade, en ander lekkergoed wat hierdie produkte of hul plaasvervangers (bv. kunsbotter en plantvette) bevat, moet nagelaat word.

Maak hierdie voorskrifte nou 'n end aan smaaklike etes? Kan 'n mens voedsel voorberei sonder om vet te gebruik? Dit is wel moeilik, maar dit kan tog gedoen word. Daar kan nie juis veel afwisseling wees nie, maar die kok moet maar bedrewendheid in die sousmaakkuns opdoen. Souse kan bestaan uit tamatie, uie, sampioene, speserye ens., vleis- en groente-ekstrakte en souspoeier. Vleis en vis moet òf sonder vet gebak, òf gekook word. Dit mag egter nie met vet in 'n pan of in die oond gebraai word nie, maar 'n dubbelbraaipot waarin die vleis sonder vet gebraai kan word, kan gebruik word, en die sous kan dan verwyder word voordat die kos opgeskep word. Waar moontlik moet al die vet van die vleis afgesny word. Skottelgeregte kan sonder die gebruik van vet in die oond gebak word. Sop en gestoofde geregte (bredies) kan die dag tevore voorberei word, en dan afgekoel word sodat die laag vet afgeskep kan word. Groente kan rou geëet word, of kan gekook of gebak word. Effens rou groente wat in 'n drukpot gekook was smaak baie lekker.

Ondersoek moet ingestel word na die samestelling van kossoorte wat in die handel aangebied word. Blikkiessop bevat dikwels room; voorbereide poedings en stoofgeregte bevat soms baie vet. As daar enige twyfel bestaan kan 'n mens aan die bemarker skryf.

Die tweede teorie, wat op baie resente proefnemings berus, pleit blykbaar die onversadigde vette wat in plant- en marine-olies voorkom, vry. Hierdie soort olie kom in graan- en mieliekiem voor, dit is moontlik die rede waarom ons growwe brood bo witbrood verkies. Om dieselfde rede is hawer en mieliemeel moontlik gesonder kosse as dié waaruit die olie gedurende die handelsvoorbereiding verwyder is—onder laasgenoemde tel sekere ontbytgraankosse wat baie gewild is. Dit is miskien van nog groter belang dat hierdie tweede teorie die gebruik van sekere kookolies toelaat; gewoonlik is hierdie olies mengsels van sonneblomsaad-olie, mielie-olie, katoensaad-olie en grondboontjie-olie. Die duur soorte bevat gewoonlik 'n groter hoeveelheid grondboontjie-olie, wat minder onversadig is as die ander. Verharde of met waterstof verbinde vette het gedurende hierdie bereiding versadig geraak en, selfs al is hulle van hierdie olies gemaak, word hulle *nie* toegelaat nie; hoewel grondboontjiebotter en alle soorte neute mag geëet word. Die vetterige vissoorte bevat baie onversadige vetsure, en is

these oils, are *not* permitted, but peanut butter and all nuts are allowed. The oily fishes are rich in unsaturated fatty acids and are perhaps beneficial. All this will naturally make the diet more palatable and acceptable, but will of course add to the calorie content. The whole subject is still very new and controversial and for the moment the problem is best approached with extreme circumspection. Perhaps dietary relaxations might be permitted on a couple of days a week.

The question must inevitably arise whether it is all worth while. It offers at least an escape for the coronary patient from the 'nothing can be done' school; it is a positive approach. More extensive studies are needed before dogmatic statements can be made but on our present knowledge it is at least a hopeful wager.

miskien voordelig. Al hierdie feite sal die dieet natuurlik smaakliker en aanneemliker maak, maar dit verhoog natuurlik ook die kalorie-inhoud. Die hele onderwerp is nog maar baie nuut en polemies, en op die oomblik moet die probleem baie versigtig benader word. Miskien kan die strengheid van die dieet vir 'n dag of twee elke week versag word.

Onvermydelik ontstaan die vraag of al hierdie beperkings die moeite werd is. Vir die lyer aan kroonslagaarsiekte bied dit ten minste 'n uitweg aan uit die ‚daar is niks aan te doen' denkwyse; dit is 'n positiewe benadering. Meer uitgebreide studies is nodig voor enige dogmatiese stellings neergelê kan word maar, bereken op ons huidige kennis, bied dit ten minste 'n goeie kans.

THE PORTALS OF ENTRY TO THE MEDICAL PROFESSION

Dr. G. v. R. Mostert's valedictory presidential address to the Northern Transvaal Branch of the Medical Association of South Africa has aroused wide public interest, evident from the comment made in the daily press. By courtesy of the *Cape Times* we reprint in this issue of the *Journal* (page 715) their leading article 'In Defence of Doctors' of 20 July 1956. Dr. Mostert's address was circulated to Association members in the first of the new series of Association newsletters, and was not published in this *Journal*, where Branch presidential addresses usually appear. There was an idea that subjects which the Association wished to discuss in committee (as it were) and not in public might be canvassed in the newsletter free from public notice. This valedictory address contained little, if any, matter that could not properly be set out in public; but what has happened does show that it was idle to expect that matter published in the newsletter would be treated as confidential.

Dr. Mostert gave expression to the commonly held view that the quality of medical students today is not what it was 30 or 40 years ago when 'the medical schools were fed almost exclusively by young men from the professional classes—the sons of doctors, of lawyers and so on'. He said that State subsidies had 'brought the study of medicine within the orbit of almost every boy or girl', and suggested that a proportion of medical students were entering the profession for the sake of social status and a lucrative future, and not in pursuance of a worthy vocational call. The present requirement for admission to a medical school is possession of an accepted matriculation certificate; Dr. Mostert maintained that a revision was required in the method of selection, but admitted that it was difficult to devise a satisfactory method. He favoured vocational tests and selection by a university selection committee which would include as a member a person specially trained in vocational tests, and emphasized that while the requirements should include 'intelligence, integrity and interest' he would place 'intelligence' last. Dr. Mostert concluded his address by declaring, in spite of what he had said, that the moral standard of medicine in this country was still very high.

The Association's Federal Council had this matter before them at their last meeting, in April 1956. Dr. Mostert's address to the Northern Transvaal Branch was delivered on 14 February, and the Branch took a resolution in which it was suggested that the Association should press for the limitation of number and the screening of medical students. The resolution came before Federal Council and after a short discussion the Council decided not to support the proposal.[1] The present policy of the Association, therefore, is against the selection of medical students on grounds other than academic.

It may well be doubted whether there is any substance in the idea that the quality of medical students has deteriorated. Fifty years and more ago medical practitioners were esteemed as men of high ideals, but that esteem hardly extended to medical students, who, judged by their conduct, were regarded by the public as being a shade more rowdy and Ben-Allenish than the students of other faculties. If the medical students of that day were actuated by high ideals they were very successful in concealing them. Nor, however, did they display much evidence of social or financial ambitions. That university students are today drawn from a wider range of social classes than formerly there is no doubt; and this is not commonly regarded as a thing to deplore. Any other screening of applicants for entry to the universities than an academic screen recalls the days when the ancient English universities were open only to adherents of the Church of England and were closed to dissenters, Roman Catholics and Jews; and when one of the express purposes for which University College, London, was founded was to provide university opportunities for such 'outsiders'. It would be highly dangerous to authorize even the most well-meaning body of persons to deprive applicants of the right of university education on any grounds other than academic.

The isolated cases of misconduct or crime on the part of individual medical students that were quoted in the address are obviously insufficient to call for radical reconstruction of the portals to the medical profession. The available disciplinary procedures for dealing with delinquent students, as with deliquent doctors, would appear to be adequate. Let us beware of the view that the medical profession ought to be recruited from a particular social class, or that the sons of business men (for example) are less eligible than the sons of doctors or other professional men. We have yet to hear that the sons of the clergy are reputed to have more of the qualities that are looked for in a parson than the sons of other men. This may be an undeserved slur, for just as misconduct by parsons, doctors and lawyers is hotter news than similar acts on the part of other people, so a few 'black sheep' amongst parsons' sons may be unduly conspicuous. The professional classes are constituted by the professional people themselves, and not from a general social class from which alone recruits to the medical profession should be drawn. In fact there is no professional class.

As for vocational tests we doubt whether any as now practised can be put forward as a suitable criterion of the character that is desirable in a medical practitioner.

1. Minute 128 (1956): S. Afr. Med. J., **30**, 576 (16 June).

PAROTID ENLARGEMENT IN MALNUTRITION

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Although the association between malnutrition and enlargement of the parotid salivary glands has been known for some considerable time,[12, 13] malnutritional parotid enlargement is an entity which is not generally recognized; and for that reason one's personal experiences are recorded in this paper. The series presented is not a large one, being limited to cases seen incidentally in surgical practice; in a series of 131 patients with enlarged parotid salivary glands, in 17 the enlargement was due to malnutrition.

Of these 17 patients 16 were Africans and 1 a Coloured person. This racial incidence is probably attributable to the fact that the non-European races belong to the lowest income-group and are consequently more likely to suffer from malnutrition. Other races are not immune and the condition has been reported in Europeans.[13]

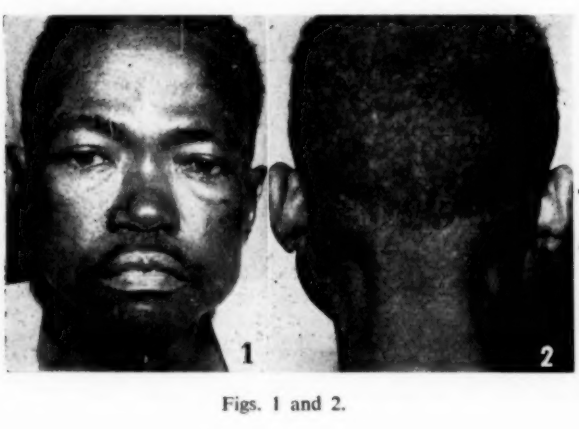
All the patients were males and although the condition has been described in females [12] this marked male preponderance has been noted before.[10, 12] The significance of this sex difference is uncertain but may be due to an increased susceptibility of the male parotid gland to nutritional disturbances.[10]

The patients in this series were all adults with the one exception of a young boy of 10 (Dr. P. Suckling's patient) but this age incidence is not valid since I have no contact with sick children. In any case the condition is said to occur at all ages.[12]

In 2 patients only one side was affected (Fig. 1) and in the other 15 both glands were enlarged (Fig. 2), although in 6 of them the one side was more enlarged than the other. This coincides fairly closely with other reported series.[12, 13] In this series none of the other salivary glands were involved but it has been reported that the submandibular and even the lacrimal glands may be similarly affected.[10, 12]

HISTOLOGY

The cause of the parotid enlargement is an increase in size of the acini. A 55% increase in size of the acini has been reported previously.[13] Fig. 3 compares the



Figs. 1 and 2.

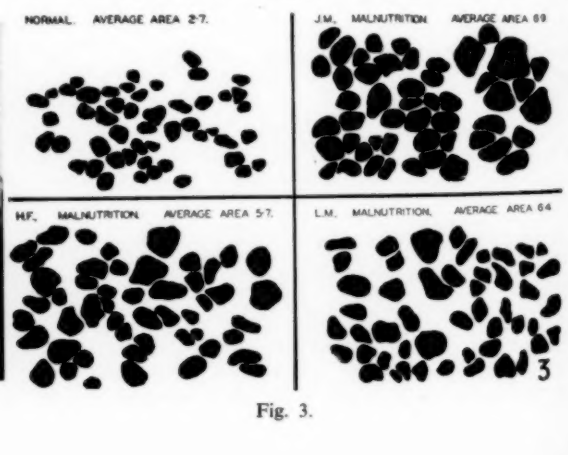
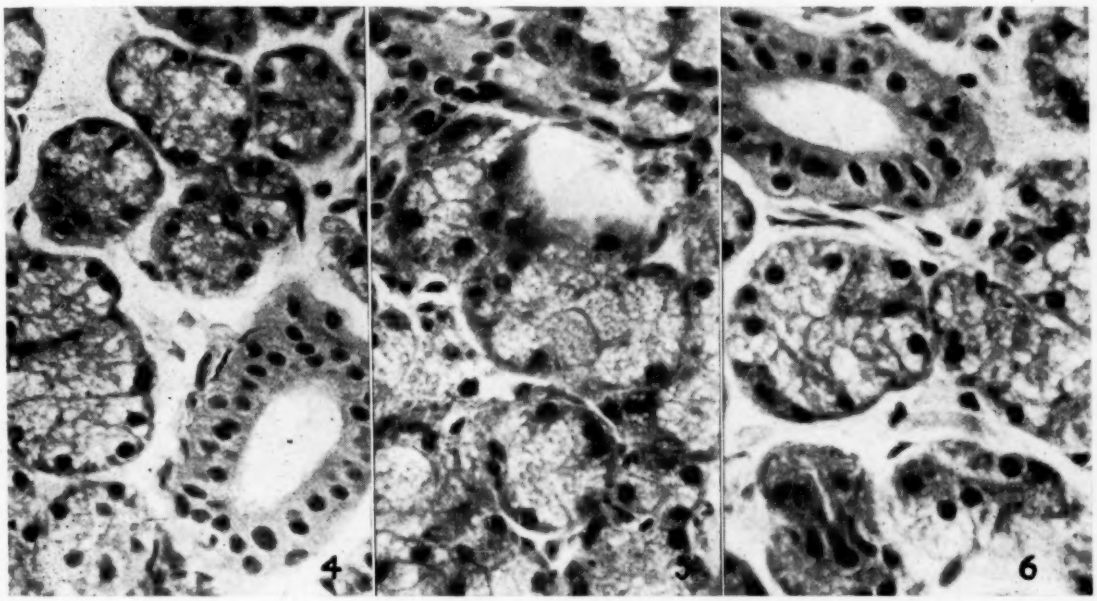

NORMAL. AVERAGE AREA 2·7.
J.M. MALNUTRITION. AVERAGE AREA 6·9
M.F. MALNUTRITION. AVERAGE AREA 5·7.
L.M. MALNUTRITION. AVERAGE AREA 6·4
3

Fig. 3.

parotid acini in 3 cases of malnutrition and in a normal person; the outlines were obtained by means of a projection microscope and the surface areas were measured with a perimeter. It is possible that there may be an increase in the number of cells, but there is no evidence of cell multiplication and mitosis [13] and so it is reasonable to assume that it is purely cellular hypertrophy[10] which is reponsible for the enlargement of the acini. The cells are distended with secretory granules which push the cell into contact with the basement membrane, displace the nuclei to the base of the cells and obliterate the little lumen usually seen in the centre of each acinus. This picture is clearly reported—this has not been seen in the cases here reported, and the interpretation of these reports is difficult; possibly they represent a more advanced stage of the condition. It has been suggested that the parotid enlargement is due to fatty infiltration,[1] but this has not been seen in this series and in any case fat is a frequent finding in normal glands[10, 13] and its presence should not be misinterpreted. An accumulation of fat in the parotids is probably the cause for the large parotids seen in very obese people.

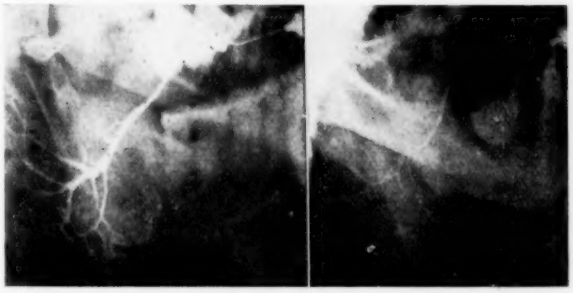
In malnutrional enlargement the parotid glands are soft and painless and have a finely granular feel if palpated between the finger tips. The parotid duct,



Figs. 4, 5 and 6.

demonstrated by Figs. 4, 5 and 6, from typical cases, but it must be kept in mind that the apparent accumulation of secretory granules with displacement of the nuclei is a normal appearance of the gland in a resting phase and so must not be considered characteristic of this condition. As a matter of fact it has already been reported that the large cells may be without any granules;[10] possibly this occurred when the histological specimen was taken during or soon after secretion. The increase of the cells in size and obliteration of the lumen is not seen in normal glands, however.

The result of this acinar hypertrophy is that there appear to be relatively fewer ducts[10] than normal, as they are pushed further apart by the enlarged acini. No other abnormality was detected histologically and McCance also could find no other abnormality in his cases.[13] On occasions other abnormalities such as crowding of the acini by ductal hyperplasia[12] and acinar atrophy with fibrous replacement[9] have been duct orifice and saliva all appear normal macroscopically. The sialographic picture corresponds to the histological appearance, as the finer ductules are widely separated by the hypertrophied acini giving a characteristic 'leafless tree' appearance (Fig. 7) unlike the normal

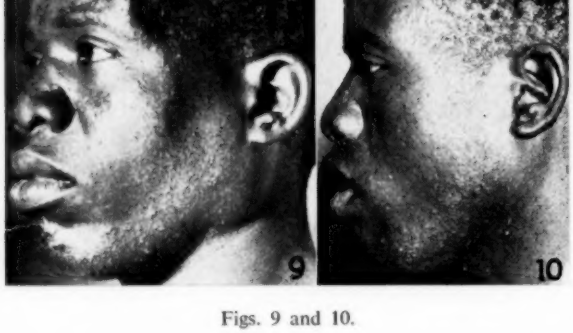


Figs. 7 and 8.

gland, which has the ductules much closer to each other (Fig. 8).

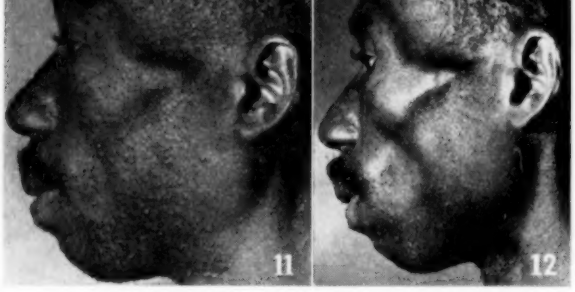
MALNUTRITION

Of the 17 patients, 10 had some obvious cause for malnutrition, such as carcinoma of the oesophagus (5 cases), carcinoma of the stomach (2), severe amoebiasis with liver abscesses, achalasia of the cardia and a psychogenic refusal to eat (1 case each). The parotid enlargement was found to be reversible after correction



Figs. 9 and 10.

of the malnutrition. This is illustrated by the patient with the achalasia of the cardia (Fig. 9) who was virtually normal 6 months after dilatation of the cardia with a hydrostatic bag (Fig. 10). Another patient (under Professor J. H. Louw) was of particular interest. He had a carcinoma of the lower end of the oesophagus with parotid enlargement (Fig. 11). Resection of the



Figs. 11 and 12.

carcinoma was found to be impossible and so a gastrostomy only was performed and vigorous gastrostomy feeding instituted. Within 23 days there was a marked decrease in the size of the parotid glands (Fig. 12). The sialogram, too, was typical of malnutrition (Fig. 13) and it also reverted to normality after 23 days (Fig. 14). This case clearly demonstrates that it is a pure malnutrition effect and that the parotid enlargement is not a result of an exaggerated oesophago-salivary

Figs. 13 and 14.

reflex due to the presence of an obstructing lesion at the lower end of the oesophagus. It does not, however, exclude the possibility that the parotid swelling is due to hypertrophy following the prolonged stimulation of the gland induced by the oesophagitis of malnutrition.[10]

One can thus conclude that in malnutrition there is enlargement of the parotid glands due to hypertrophy of the cells constituting the acini, and that this may possibly be a 'work hypertrophy' following on prolonged stimulation of the gland by an exaggerated oesophago-salivary reflex originating in the oesophagitis of malnutrition. The condition is reversible if the malnutrition is corrected.

The other 7 patients reported here did not have any obvious cause for, nor other manifestations of, malnutrition and the parotid enlargement was a purely incidental finding. The lesion was in every way identical to that already described and one assumed that the parotid swelling was probably a result of a previous period of malnutrition (although such a history was not always obtained). This failure of the gland to revert to its normal size after recovery from malnutrition may be interpreted as the 'work hypertrophy' of the gland which has been described as coming on with the excessive chewing during recovery from malnutrition.[5] It only occurs with a sudden increase of food after malnutrition,[13] and particularly if there is a high proportion of bread in the diet.[15, 16] This is probably also the explanation for the enlarged parotids sometimes seen in people who habitually overeat.

ASSOCIATED PATHOLOGY

Some attempt was made to assess the function of these enlarged glands by studying the salivary amylase and volume of secretion of a few cases. The salivary amylase varied within a wide range and no clear picture could be obtained, although it has been reported that about 40% of cases have a slightly raised serum amylase.[12] The volume of salivary secretion, obtained by means of a cannula inserted into the parotid duct, was lower than normal; but conclusions cannot justifiably be drawn from this finding because only a few cases were

investigated. However, of the few so examined, not one had a secretion of over 6 c.c. per hour under basal conditions 3 hours after the last meal, whereas the average in normal controls has been found to be 7·5 c.c. per hour. This finding is unexpected since an increased flow would be expected and sialorrhoea has previously been reported in this condition.[10, 12] A possible explanation for this low salivary flow is that all the cases so investigated were patients with oesophageal obstruction, which possibly produced subclinical dehydration that was reflected in a low salivary secretion. One finding which tends to confirm that sialorrhoea does in fact occur was that on 2 occasions the volume of saliva decreased significantly after correction of the malnutrition and return of the gland to a normal size.

Other authors have reported a variety of functional disorders such as porphyrin-like fluorescence in the saliva,[10] large amounts of thiocyanate in the saliva,[10] increased response to pilocarpine,[12] and a high serum-content of pseudo-cholinesterase.[13]

One interesting observation which has been reported is that serous acini are much more susceptible to malnutrition than mucous acini,[9, 10] which explains why the parotid glands, which consist almost entirely of serous acini, are more often affected than the mixed (serous and mucous) submandibular glands. If the latter are affected then the serous acini only are involved until a late stage, when the mucous acini also become affected.[9]

As can be expected, malnutritional parotid enlargement is often seen in association with other manifestations of malnutrition such as pellagra,[10] cirrhosis of the liver,[1, 10] and gynaecomastia[7]—the latter was encountered in 3 of the patients reported here. It is possible that the testicular or hepatic lesions seen with malnutrition produce a disturbance of hormonal balance which in turn is responsible for the parotid enlargement.[10]

It has been pointed out that 10% of the patients with malnutritional parotid enlargement also show diabetes,[12] but it must be kept in mind that parotid enlargement is not uncommon in diabetes.[1, 3] A hyperglycaemic [2, 3, 11] as well as a hypoglycaemic factor[1, 14] has been found in the parotid; certain workers consider the parotid enlargement in diabetes to be a compensatory mechanism to produce a blood-sugar lowering factor in hypo-insulinism[6, 7] and attempts have even been made to encourage the absorption of this factor by ligation of the parotid duct to lower the blood-sugar.[17] It is, however, uncertain whether significant amounts of either factor are secreted by the parotid,[1, 8] and in this series diabetes was not encountered.

The treatment is obviously to correct the malnutrition, keeping in mind that excessive eating of bread especially may in turn produce parotid enlargement. Deep X-ray therapy also produces a significant effect on the glandular enlargement,[12] but it is not usually required.

SUMMARY

Parotid enlargement occurs during malnutrition. It is due to hypertrophy of the cells of the gland and the condition is reversible with a return to adequate nutrition. This condition is particularly common in males and is possibly due to a work hypertrophy following excessive stimulation of the gland by malnutrition changes in the oesophagus.

A similar condition occurs in people who are recovering from malnutrition, particularly if the feeding is rapid and a large amount of bread is consumed. This may be a work hypertrophy due to the excessive stimulation by the chewing of the bread in the diet.

I wish to thank the Superintendent of the Groote Schuur Hospital for permission to report these cases; the clinicians who have referred many of these cases to me; the hospital X-ray Department for their co-operation; the Pathology Department of the University of Cape Town for their assistance, and Dr. Kihn for the needle biopsies of some of the cases.

The expenses of this report have been defrayed by a grant from the Dr. C. L. Herman Research Fund.

REFERENCES

1. Annotation (1954): Lancet, **2,** 1008.
2. Birnkrant, W. B. (1941): J. Lab. Clin. Med., **26,** 1009.
3. Birnkrant, W. B. and Shapiro, R. (1942): *Ibid.*, **27,** 510.
4. Cahane, M. and Cahane, F. (1941): Rev. franç. Endocr., **8,** 398 (after Birnkrant *et al.*[3]).
5. Davies, J. N. P. (1948): Lancet, **1,** 317.
6. Dobreff, M. (1936): Dtsch. med. Wschr., **62,** 67.
7. Ferretti, G. (1936): G. Clin. med., **17,** 1305.
8. Gault, S. D. (1954): J. Lab. Clin. Med., **43,** 119.
9. Gillman, J., Gilbert, C. and Gillman, T. (1947): S. Afr. J. Med. Sci., **12,** 99.
10. Gillman, J. and Gillman, T. (1951): *Perspectives in Human* Malnutrition. New York: Grune and Stratton.
11. Hiki, Y. Akazaki, K., Bann, T., Miyazaki, Y. and Takizawa, N. (1932): Trans. Soc. path. jap., **22,** 273 (after Birnkrant *et al.*[3]).
12. Kenawy, M. R. (1937): Trans. Roy. Soc. Trop. Med. Hyg., **31,** 339.
13. McCance, R. A., Dean, R. F. A. and Barrett, A. M. (1951): Spec. Rep. Ser. Med. Res. Coun. (Lond.). No. 275, p. 135. London: H. M. Stat. Office.
14. Takacs, L. (1933): Orv. Hetil., **77,** 659 (after Birnkrant *et al.*[3]).
15. Widdowson, E. M. and Thrussell, L. A. (1951): Spec. Rep. Ser. Med. Res. Coun. (Lond.) No. 275, p. 296. London: H. M. Stat. Office.
16. Widdowson, E. M. (1951): *Ibid.*, p. 313.
17. Zimmerman, L. M. (1932): Arch. Intern. Med., **49,** 409.

ABSTRACT : UITTREKSEL

Maritime Aspects of Venereal Disease Control. Annexure to World Health Organization Technical Report Series No. 92. Geneva. July 1955.

In a reply to questionnaires to 52 countries it was found that in 20% of the port clinics dark-field diagnosis of syphilis was not available, that in the majority of the clinics the result of a blood test took longer than 48 hours, that repository penicillin was used in only a few clinics, and that intensive courses for syphilis were rarely used.

The WHO expert committee does not favour indiscriminate use for seafarers of penicillin for prophylaxis or preventive purposes either by mouth or by injection. Seamen having penile sores or urethral discharges while at sea should always be instructed to consult a venereal disease treatment centre or qualified physician at the next port of call. F.W.F.P.

A PUBLIC OPHTHALMOLOGICAL SERVICE

SUGGESTED SCHEME TO INCLUDE MEDICAL PRACTITIONERS AND OPTICIANS*

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Pietermaritzburg

Considerable progress has been made during the last 20 years in the provision of ophthalmic services to the public of South Africa. But there is still much to do in this direction, and now would seem to be an appropriate time to take stock of the situation, and consider proposals to improve the position with the resources at present available or likely to be available in the foreseeable future.

Let it at once be said that it is no part of the object of this paper to level criticisms against sight-testing opticians, a body of men who, both here and in other countries, can carry out a considerable service to the community. But there are reasons why the present position, in which a majority of the refractions in this country are carried out by opticians, falls somewhat short of the ideal at which we should aim.

Let us consider first the amount of work to be done and the personnel available to do it.

There are some 77 ophthalmologists in active practice in this country to serve a population of about 2½ million. So that leaving aside for the moment the question of distribution, it is fair to estimate that there is one ophthalmologist to about 30,000 of the European population. It is worth recording that of this number rather more than 600,000 are over 45 years of age and consequently need more or less regular ophthalmic examination. This is not an altogether satisfactory position, even in existing conditions in which the majority of refractions are carried out by opticians. I do not know of any reliable figures in this connection, but I believe that not many years ago the proportion in Great Britain outside London was about one ophthalmologist to 20,000 population.

To this has to be added the vast imponderable of non-European practice, and here the position is likely to undergo considerable change in the fairly near future. At present, owing to illiteracy, comparatively few non-Europeans have to be provided with presbyopic spectacles, but this number must increase *pari passu* with the increase in Native education. So that leaving aside the Native's predilection for glasses as an adornment or a bringer of prestige (I would estimate that at least 90% of the glasses at present worn by non-Europeans of less than presbyopic age fulfil these functions only) the amount of work done in non-European refraction will shortly become a formidable problem.

One is thus led to the conclusion that even with optimum distribution there simply are not enough ophthalmologists at present to provide adequate ophthalmic services for the population of the Union without assistance. As any great increase in the number of ophthalmologists is likely to be a slow and dubious quantity, the need for assistance stands out.

Fig. 1 shows the towns in which ophthalmologists are known to be in practice in the Union. It is probably fairly complete. Fig. 2 is an attempt to give a comparative picture of the distribution of opticians, i.e. towns in which opticians are in practice. It is also probably fairly complete, though small inaccuracies certainly exist in both, which, however, are not likely to affect

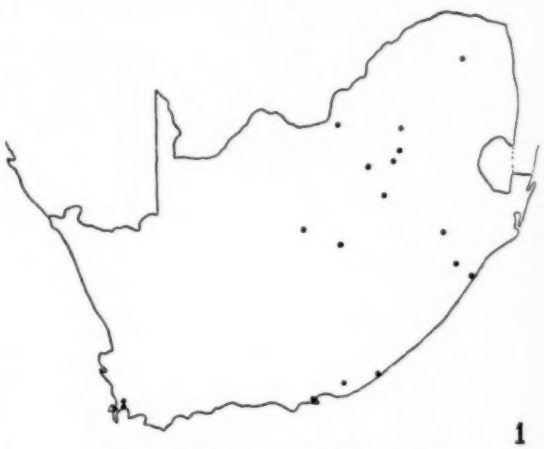

Fig. 1. Distribution of ophthalmologists.

the over-all picture. The first point which emerges is that while there are 77 ophthalmologists there are 337 opticians. In both cases there is a concentration in the more densely populated areas, and so the pattern of the two maps coincides to some extent, but of course there are many more opticians scattered in the country districts. Comparing Fig. 3, showing the Provincial hospitals,† however, it can be seen that there is a much wider spread of hospitals than there is of ophthalmologists, and one comparable with that of opticians. In Natal, for example, there are opticians in 8 towns and hospitals in 14. So that to meet the problem of distribution it is quite clear that the hospital is a most important factor, and it is on them that any scheme for organizing ophthalmic services must be based. It is realized of course that with the personnel at present available and the great geographical difficulties in some parts of the Union, a comprehensive plan is not yet possible. For example there is no ophthalmologist between Cape Town and Port Elizabeth to the East and Bloemfontein in the North-east apart from 2 close

* A paper presented at the South African Medical Congress, Pretoria, October 1955.

† Except those in the Transvaal, about which information was lacking.

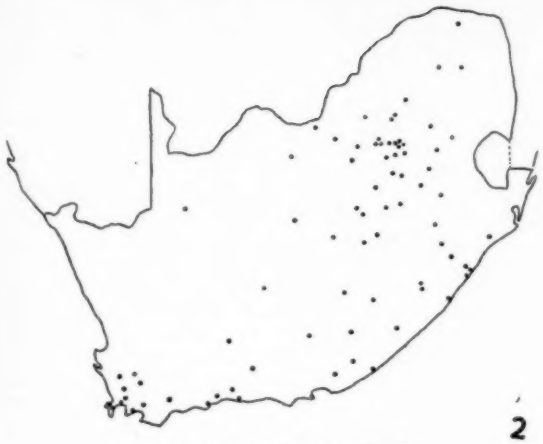

Fig. 2. Distribution of opticians.

to Cape Town. Much of this area must be served by opticians while this state of affairs exists. But there is no reason why one should not look into a future in which there may be a larger number and better distribution of ophthalmologists. Already in Natal and on the Reef the scheme to be described could be put into operation with very little, if any, addition to existing personnel.

From these maps then emerges the glimmerings of a possible plan—a plan that cannot, obviously, be introduced without much preliminary organization and scheming; and a plan that is perhaps Utopian because it depends for its success upon cooperation and give-and-take between two bodies of men (ophthalmologists and opticians) who have not so far been remarkable for an ability to see eye to eye, and because a certain amount of sacrifice, both of income and of convenience, may be necessary, at all events in the early stages, from those operating the scheme. However, it could work. There is no reason why it should not.

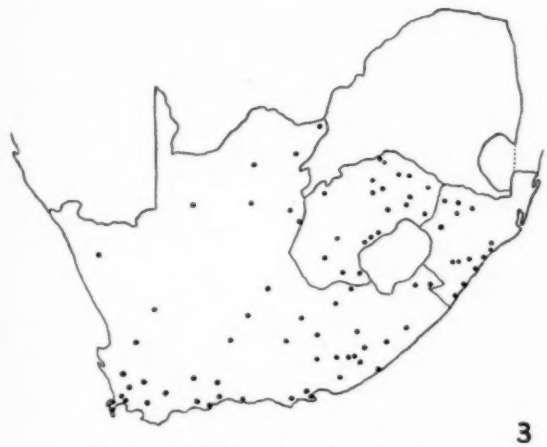

Fig. 3. Distribution of Provincial hospitals.

PROPOSED SCHEME

Briefly, the proposals envisage a series of integrated ophthalmic clinics based on the main Provincial hospitals but with antennae connecting with the smaller hospitals, and manned by one or more ophthalmologists, who would be the responsible people in charge of the clinics, plus an appropriate number of refractionists.

This seems a suitable place to mention part-time ophthalmologists. The services of such persons, who carry out a certain amount of eye work, including refractions, in addition to general practice, are fairly extensively used in some provincial areas in Great Britain. There are no specific minimum qualifications laid down. Some of them have a D.O.M.S., others have merely spent a sufficient time working in the ophthalmic department of a teaching hospital to acquire a reasonable proficiency.

Admittedly, it might be more difficult to arrange the necessary instruction for such practitioners in South Africa, where there are relatively few teaching hospitals at which such facilities could be made available. On the other hand the number requiring instruction would be correspondingly less.

For a postgraduate an adequate knowledge could probably be acquired in 6 months. A deep knowledge of the subject is of course not necessary. He should know 3 things:

1. How to cope with refractions en masse.
2. How to deal with the commoner eye diseases, or at all events how to institute treatment.
3. His own limitations.

He need know little of ophthalmic surgery other than of the minor procedures. (These are simply observations on minimum requirements, and are not to be taken as in any way restrictive.) Such a practitioner could be used in one of two ways—either as assistant to an ophthalmologist in charge of a large central clinic, or as the medical officer in charge of one of the smaller peripheral clinics with power to refer to the central clinic cases requiring special attention.

The exact manner in which clinics would be organized will of course depend upon geographical considerations, available personnel, and the distribution of hospitals within the area. The central clinics would be served by one or more units consisting of an ophthalmologist, one or more part-time specialists if available, and an appropriate number of refractionists. Some, or even many, of the peripheral clinics would have a part-time man at their head. If personnel permits of more than one unit, then the number of weekly sessions held would be divided amongst the units available.

SCHEME FOR NATAL

It is perhaps easiest to describe the proposed scheme in terms of a specific area, and although it is realized that each area will have its own particular problems, it should be possible to adjust the scheme to any given area. As I am naturally most familiar with local conditions I propose to demonstrate with the aid of the diagram in Fig. 4 how the scheme would operate in Natal. The diagram shows the available Provincial

hospitals (of which Addington, Wentworth, King Edward VIII, Grey's and Edendale are major hospitals). Ophthalmologists are available in Durban (6), Maritzburg (2), and Ladysmith (1).* There are also some 36

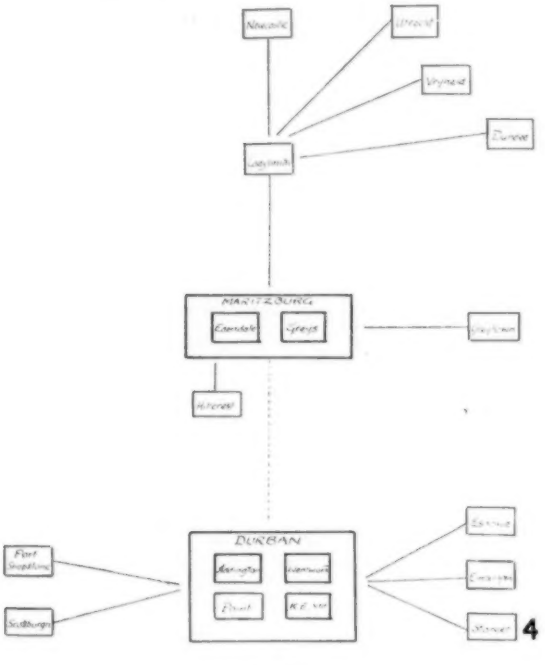

Fig. 4.

opticians in practice in Natal. Many—even most—of these might not at first join the scheme, but it is likely that as time passes and its advantages become apparent an increasing number of the public will fall into the habit of attending the clinics rather than the optician, and optician recruits will probably increase in number. Fig. 4 is self-explanatory, and shows how the main and subsidiary hospitals could be linked up. It is envisaged that at the main hospitals two or three clinics per week might be needed initially, plus one operating session. The provision of these facilities would of course be the responsibility of the Provincial Health Services.

The ophthalmologists staffing the clinics would be remunerated on a sessional basis. The refractionists might be paid a sessional fee for their attendance at clinics, but the major part of their income would derive from the provision of spectacles for clinic patients. The price of glasses for such patients would be controlled, but a full range of frames would be available.

The everyday working of the clinics would largely be the concern of the ophthalmologist in charge, but in general each patient would be seen in turn by him and he would deal with 'medical' and treatment cases, setting aside the refractions for the attention of the refractionist and/or himself as can best be fitted in.

All prescriptions for glasses would be initialled by the ophthalmologist before dispensing.

It must be emphasized that these clinics are primarily intended to meet the requirements of that section of the community who cannot afford the services of a private ophthalmologist, and who are not covered by any form of Medical Aid. There is however, a considerable section of the population in the lower and middle income group who either dislike the idea of attending a hospital clinic, or who cannot afford the time to wait their turn. It is suggested that to cater for such persons a scheme similar to the British N.O.T.B. should be instituted. There should be an income ceiling for participation in such a scheme and, for this, and indeed for the proper functioning of the hospital clinics, an adequate system of almonership would be essential. These patients would pay a reduced fee—an amount bearing a realistic relationship to their income. They would attend within specified times, either at the ophthalmologist's rooms or at the hospital, and each would be given an appointment time, so that the ophthalmologist would be able to deal with a number at each session. At least one such session per week should be held after normal office working hours. These patients would be expected to get their glasses from the optician-refractionists employed by the Service.

It would be a fairly simple matter to dovetail normal practice and Medical Aid work into the framework of the scheme, and no particular comment in this connection seems to be necessary.

The problem of the registration of opticians now falls easily into place. There would be a register of optician-refractionists who would carry out no refractions outside the clinic work, and who would be accorded the status of Medical Auxiliaries. Those opticians electing to remain outside the scheme would have no such status, and no register.

DISCUSSION

The above proposals would not of course eliminate some of the undesirable features which many see in the service at present offered by opticians, for there would still be opticians operating outside the service. There are two ways of circumventing these difficulties. One is to legislate against them and the other is to offer a more attractive alternative.

The majority of people who patronize opticians do so because (1) they do not consider that sight-testing is a medical service, or (2) they feel they cannot afford the ophthlamologist's fee. Both these considerations are fallacious for the following reasons:

1. Refraction should be only a part of a routine ophthalmic examination. The mechanics of sight-testing may very well be carried out as effectively by an optician as by an ophthalmologist—hence the proposed employment of the optician in the clinics above described—but in bringing to bear professional judgment on the findings the ophthalmologist is probably a good deal more reliable. Furthermore the ophthal-

* Since this was written it has been learnt that the ophthalmologist at Ladysmith has retired.

mologist can bring to bear on the problem a balanced judgment unbiassed by the financial consideration of whether or not glasses should be prescribed in a particular case. This brings one to the most fundamental statement of policy which ophthalmologists should uphold in any proposed scheme. No person who is financially interested in the supply of spectacles should be the final arbiter in a decision to prescribe them.

2. It is extremely questionable whether an ametropic person habitually attending an ophthalmologist will in fact pay more over a longish period than one attending an optician. Experience shows that the latter, over a period of time, tends to acquire a larger number of pairs of spectacles than the former, and what is gained in one direction is probably lost in another.

Legislation in medical and allied matters is always to be avoided if possible—there are always those who see discrimination in every provision. I believe that given time and conscientious service from the participants such a scheme as the above would gradually resolve the problem of the sight-testing optician so as to make any form of legislation unnecessary.

Education of the public and a certain amount of propaganda, in which our general-practitioner colleagues and in particular school medical officers could help us a good deal, would contribute greatly to the success of the proposed scheme.

Two further points deserve mention. Firstly, any ophthalmologist who wished to have no part in the scheme could continue in ordinary private practice as at present. It is unlikely that his income would be affected to any serious extent.

Secondly, the institution of the scheme would not preclude legislation at some later date in respect of opticians outside the scheme if their numbers remained considerable and the relative problems persisted. One has in mind such questions as price-control of spectacles, the activities of intinerant opticians, the use of drugs, and the examination of children.

Ophthalmologists are in a singular position *vis à vis* other medical practitioners in that they have to contend with organized non-medical competition. There are naturally two opinions whether this competition is beneficial to the general public. Whether or not it is beneficial to the competitors should not of course be a considerable factor.

More often than not the medical profession tends to get a 'bad press'. Therefore let us avoid any accusation, even by uninformed persons, of sectarianism. Let us offer to the optician some measure of cooperation, and thus to the public the best of both worlds, in a combined attempt to give them a comprehensive service of which they will be happy to take advantage.

SUMMARY

After a statement of the problem a suggested scheme is outlined for the provision of ophthalmological services (including refractions) in which both medical practitioners and opticians might participate. Details are given indicating how the suggested scheme might be applied in Natal.

A PSYCHOLOGICAL APPROACH TO ALCOHOLISM*

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Enlightened medical and psychological knowledge has done little to lessen the prejudice and discrimination directed against the alcoholic. In South Africa, only the skilled and trained personnel who work in the field are familiar with the 'disease factor' in alcoholism and its implications; there is still an urgent need for enlightenment of the public. Even among professional groups prejudices still exist. In the Southern Transvaal, for instance, the majority of hospital boards do not admit alcoholics as such for treatment. 'Hospitals,' they say, 'are designed for sick people and not for drunkards.' Consequently, where medical supervision is indicated the alcoholic is usually hospitalized for 'acute anxiety' or a 'liver complaint'. Alcoholism is still viewed in the light of 'bad character' and 'weak will-power', and the majority of alcoholics must still endure the pull-yourself-together doctrine with its concomitant emotional appeals, morality lectures, threats, promises, and the like.

The study of alcoholism has mainly developed under the interests represented by psychology, psychiatry, sociology, religion, and economics. These diverse influences have visibly contributed to the contradictory concepts and the fragmentary nature of theory in this field. Moreover the general urgency of the problem and the desire for rapid progress lend acceptance to technically faulty work that would not pass muster in other fields. While semantic difficulties seem almost inherent in the social sciences, the study of alcoholism has added to this confusion by introducing a myriad of terms—'chronic alcoholism,' 'acute alcoholism,' 'alcohol addiction,' 'pathologic alcoholism,' 'primary alcoholism,' 'secondary alcoholism,' 'toxic alcoholism,' to mention only a few—all varyingly defined and applied with neither consistency nor uniformity. An attempt to define these conditions operationally is the one measure that will reduce the amount of confusion and controversy which abounds in this field.

DISCUSSION OF A DEFINITION OF ALCOHOLISM

The term 'alcoholism' is itself a matter of dispute. In some circles the term 'problem drinking' is preferred,

* Summary of thesis in partial fulfilment of B.A. hons. degree in psychology, University of the Witwatersrand.

but the point is that we are told little about 'alcoholics' or 'problem drinkers' other than the descriptive facts that they are addicted to alcohol, that they drink excessively, that they crave for alcohol, and that they cannot control their drinking. We venture therefore to submit the following definition: *Alcoholism is a psycho-biological malfunction which manifests itself in a compulsive and progressive craving for alcohol, as the result of a pattern of conditioning, habit formation, and a biological inability to cope with alcohol.*

Let us discuss this definition. We term alcoholism a 'psycho-biological malfunction' because neither the pure psychological explanations of the condition nor the biological theories on their own are very illuminating.

The psychological explanations range from various Freudian theories, which include an emphasis on the oral erotic aspects, repressed homosexuality, and unconscious guilt feelings brought about by thwarted aggressiveness in the erotic field, to a behaviouristic emphasis on 'habit systems,' 'memory-traces,' and the like. On the other hand, some theorists consider alcoholism to be solely a product of such physical factors as cerebral lesions, liver deficiencies and endocrine imbalance. While there is evidence to suggest that the root-cause of alcoholism is not to be found in the psychological make-up or social environment of the individual but in his physiological interior (it would appear that some individuals, because of inherent physiological 'defects,' are unable to digest or assimilate alcohol in the 'normal' manner) it is the psychological factors which finally determine whether or not the individual becomes an alcoholic. Conversely, the role of the biological factors in accounting for alcoholism must not be underestimated, for the evidence indicates that an actual *tissue need* for alcohol, as a result of certain physiological and biochemical changes, in fact underlies the inordinate craving for drink.[3]

While no one has conclusively demonstrated that these obvious physio-pathological factors are not in fact entirely secondary to prolonged over-indulgence, the majority of writers regard the alcoholic's characteristic 'craving for and sensitivity to alcohol' as a hereditary predisposition which usually comes to the fore after many years of progressive but controlled drinking. It must be noted, however, that this does not mean that 'alcoholism is hereditary'. Many individuals may have this 'physiological sensitivity,' but because of an ability to cope with environmental stress, they never become 'alcoholics'. Thus, ultimately, 'personality' furnishes the terrain on which alcohol addiction may or may not grow. But to ask, 'what is more important in accounting for alcoholism, the psychological or the physiological factors?' is as meaningless and as futile as the age-worn 'nature-nurture' controversy.

Referring to our definition again, the psychology of alcoholism embraces *a pattern of conditioning* (*and*) *habit formation.* The sequence may be as follows:

The individual in stress situations makes a number of different responses, one of which might be the consumption of alcohol, which affords him temporary relief. Repetition of this behaviour pattern eventually leads to a conditioned response between *stress* and *consumption of alcohol.* In terms of 'stimulus generalization', an endless variety of stimuli are later perceived as 'stress situations'. The consequent increase in drinking behaviour may cause financial difficulties, domestic problems, etc. This may soon occasion feelings of guilt and perhaps a deterioration in health, which in turn add to the already mounting stress. This 'self-perpetuated stress' precipitates further drinking (in terms of the already-established conditioned response) which affords the individual the usual short-lived relief. When this wears off the individual is again faced with his difficulties and problems, and in this manner, a circular pattern of causation is pre-eminently the psychological mechanism maintaining the phenomena of alcoholism.

There are, of course, many variations of the pattern, but the vicious circle is apparent in all cases. This, as we shall outline, has far-reaching implications for therapy. It may be indicated at this stage that the vicious circle must be broken at several strategic points, not at one alone, if a cure is to be established.

The underlying dynamics of this vicious circle are best understood in terms of the effect of alcohol on the human brain. The active substance in any alcoholic beverage is ethyl alcohol, which, contrary to popular opinion, is an *anaesthetic drug* and acts as a *depressant* and not as a stimulant. The deceptive appearance of stimulation arises from the release of the lower nervous centres from the control of the higher by the narcotization of the latter. In other words, the first effect of alcohol on the brain is the deadening or anaesthesia of the higher centres (which determine the functions of self-criticism and judgment, the power of inhibition, etc.) thus causing a temporary depression of the drinker's tensions, inhibitions, anxieties and general inadequacies. Hence the individual appears stimulated.

Before turning to the therapeutic considerations of alcoholism, we should like to cite some typical examples of the loose thinking and vague generalizations so prevalent in this field. One writer, with no experimental backing, states categorically that 'the pre-alcoholic personality is always distinctly inhibitory.'[4] Elsewhere, we read that 'at least 90% of all abnormal drinkers are predominantly of the introverted type.'[5] Further, we hear much about the 'typical alcoholic'. It is important to verify whether we are in fact entitled to describe anyone as a 'typical alcoholic' and it is equally important to know whether there is any justification for terms like 'the pre-alcoholic personality' or 'the alcoholic personality'.

The results of a *preliminary investigation* conducted by the present writer provide no justification for the use of these terms. The central questions of the enquiry were phrased as follows: (1) Is there a personality type with a relatively constant combination of psychological traits which renders the individual especially susceptible to the intemperate use of alcohol? (2) If there is no unitary personality type among alcoholics, is there perhaps a variety of different but well-defined personality types?* The results indicated that alcoholics are not a homogeneous group as far as temperament or personality make-up is concerned. They could be distinguished from the non-alcoholic controls only roughly and with many exceptions. We therefore

* The definition of the word 'personality' as used here is: *Personality is the dynamic organization within the individual of those psychophysical systems that determine his unique adjustments to his environment.* Allport, G. W. (1951): *Personality: A Psychological Interpretation*, p. 48. London: Constable.

concluded that we cannot speak of a personality structure which is typical of the alcoholic, and that compulsive drinking seems to depend upon the total effect of environmental stress upon a particular individual who has a biological inability to cope with alcohol.

THERAPY

Turning now to the therapeutic procedures for combating alcoholism in South Africa, we must note that the reported percentages of 'cures' are at best disappointing. This is not surprising when we recall that the usual approach to the alcoholic in this country is to hospitalize him for a short time, during which he is kept off alcohol and given vitamin injections. While this is a useful means of preparing the patient for further treatment, all too often it is administered as a cure in itself. There are, however, several sanatoria, homes and clinics which provide far more extensive means of treatment for the alcoholic. But even the measures adopted there, when viewed in the light of the vicious circle previously outlined, are inadequate. The mere regime of physical rehabilitation coupled with occupational therapy and 'healthy living' (as provided by some of these specialized homes and clinics) is insufficient. Unfortunately, the expectation of a possible 'panacea approach' is still prevalent among many clinicians, so that the problem is generally tackled within a unitary, or at best a 'bimodal', frame of reference.

Each of the following curatives and therapies has made energetic attempts to hold the centre of the stage as *prima donna* but, unhappily, each in turn has been relegated to the chorus. They include: relaxation therapy, psycho-analysis, conditioned reflex therapy, vitamin therapy, hypnotherapy, and the various drug therapies. The fault lies not with the methods, but with the failure to combine the advantages offered by each. For instance, it is estimated that psychotherapies, as they are applied at present without many selective criteria, may have an average success of 25-30% in terms of 2-4 years of total abstinence,[1] whereas when combined with conditioned-reflex therapy, Cotlier lists cures ranging from 50-75%.[2]

On the basis of 32 alcoholic case studies and Thematic Apperception Test interpretations (TAT), we submit that the consequences of alcoholism usually require a series of active steps in order to break the compulsion, as well as substitutive treatment (the fostering of hobbies and other recreational and occupational pursuits) and other forms of environmental manipulation, which all form part of a wide and all-embracing re-educative programme. The final and complete dissolution of the aforementioned vicious circle can usually be achieved by applying the following fourfold plan.

1. *Active measures to break the compulsion.* The gradual weaning process is supplemented by large doses of vitamin preparations administered intramuscularly. When the patient has regained his physical well-being, certain steps are recommended to ensure his total abstinence from drink while undergoing psychotherapy. This is best achieved by either administering a course of conditioned-reflex therapy or else tetraethylthiuram disulphide (Antabuse). (1) The former procedure consists of repeated sessions in which the individual is given a dose of emetine or apomorphine and shortly after either sees, smells or drinks various alcoholic beverages. The emetine or apomorphine induces nausea and vomiting, and because this becomes associated with the alcohol, the patient develops an aversion to it. The unconditioned stimulus is concerned with the elicitation of nausea or vomiting, and various alcoholic beverages represent the conditioned stimulus. This, it must be stressed again, is not intended as 'a cure for alcoholism'. Experience has indicated that in many cases, this conditioned aversion to alcohol breaks down after a few months, even when the response is 'reinforced'.[6] But if the individual can be made to avoid the apparently inevitable 'slips' during therapy, a positive prognosis is greatly facilitated. (2) The use of tetraethylthiuram disulphide is less involved than the conditioned-reflex therapy. The patient takes the drug orally in tablet form every day (any attempt to administer it without the patient's knowledge is contra-indicated) and it creates a sensitivity to alcohol, so that the patient cannot take alcohol without experiencing disagreeable and often violent reactions. This, unless medically inadvisable, is a valuable aid in rendering the alcoholic more amenable to psychotherapy.

2. *Educative Procedures.* By attending group or individual discussions, the alcoholic must learn the nature of his condition. He must be led to realize that he is suffering from an incurable disease (in the sense that he can never drink socially again) and that complete abstinence from any alcoholic beverage whatsoever, is his only salvation.

3. *Psychotherapeutic Procedures.* Individual psychotherapy should consist of (i) diagnostic interviews, i.e. a psychological and social diagnosis—an evaluation of the interaction of the patient and his environment; and (ii) treatment, which is designed to help the patient to gain 'insight'. Insight into, say, the relation between A and B in the life situation is a function of an intellectual and an affective bond between the two. It is a matter of *knowing* and *feeling* into the situation. The ultimate aim of psychotherapy is to ensure that the alcoholic remains abstinent by way of favourable readjustments in his personality. This implies the use of techniques which are designed to uncover the true motives behind the addiction and to provide the patient with a basis for readjustment through insight into his motives.

4. *Socio-economic Procedures.* A specially-trained social worker should visit the home of the alcoholic with the primary purpose of explaining to his family the 'disease factor' in alcoholism. Furthermore, the alcoholic should receive advice and help in securing employment, the correction of faulty home-environment, associates, etc., and aid in smoothing out domestic and other incompatibilities.

We are not suggesting that this fourfold plan is *the* cure for alcoholism. Nor are we under the impression that it constitutes anything novel. What we are attempting to convey is simply that all too often, therapists are prone to overlook the importance of each of these steps in turn, and unless this wider therapeutic approach is widely adopted, few of the alleged 90,000 European

alcoholics in South Africa will escape the searing effects of their terrible affliction.

A most useful adjunct to psychotherapy is progressive relaxation, since repeated practice of relaxation inhibits the tensions which may lead to drink. In some circles, injections of adrenal cortical extract are lauded. The successes claimed by Alcoholics Anonymous range from 50 to 70%. We submit that their successes are due largely to an effective mobilization of emotional relationships and, hence, participation in this movement should be encouraged where the patient's personality is considered amenable to their teachings.

Finally, we should like to emphasize again that since alcoholics form a heterogenous population embracing different and even antagonistic personality-types, no one treatment or approach can prove beneficial to all abnormal drinkers.

SUMMARY

1. Despite the important strides which have recently been made in the scientific study of alcoholism, there is still an urgent need for widespread public enlightenment concerning the 'disease factor' and its implications.

2. Ill-defined and contradictory concepts lend general confusion to the field. The general orientation should lean towards operationism.

3. The following definition is submitted and amplified: Alcoholism is a psycho-biological malfunction which manifests itself in a compulsive and progressive craving for alcohol, as the result of a pattern of conditioning, habit formation, and a biological inability to cope with alcohol.

4. The many generalizations about alcoholics so prevalent in the literature are not borne out by controlled studies. The so-called 'typical alcoholic' is a myth.

5. The emphasis in the rehabilitation of the alcoholic must essentially be on a *synthesis*, which would embrace active measures combined with educative procedures and psychotherapeutic and socio-economic procedures, as well as innumerable adjunctive measures such as chemotherapy, drug therapy, vitamin therapy and the like.

REFERENCES

1. Jellinek, E. M. (1942): *Alcohol Addiction and Chronic Alcoholism*, p. 79. New Haven: Yale University Press.
2. Hampton, P. J. (1947): J. Soc. Psychol. **25**, 162.
3. Kolle, K. (1939): Allg. Z. Psychiat., **112**, 397.
4. Salter, A. (1952): *Conditioned Reflex Therapy*, p. 191. London: George Allen & Unwin Ltd.
5. Strecker, E. A. and Chambers, F. T. jr. (1939): *Alcohol, One Man's Meat*, pp. 46-47. New York: Macmillan.
6. Voegtlin, W. L., Lemere, F. and Broz, W. (1940): Quart J. Stud. Alcohol, **1**, 501.

NOTES ON THE OCCURRENCE OF CERVICAL RIBS

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In a mass-radiographic survey of 7,569 Natives from the Northern and Eastern Transvaal, Schneider[1] detected 40 cases (0·53%) with cervical rib. This is a much higher figure than that obtained by Crimm,[2] who found only 0·16% of all congenital rib abnormalities in a group of 70,877 people in the United States.

A study of 67,716 people of all races, in Natal and North-Western Cape Province, is reported here. A total of 325 cases (0·48%) with cervical rib was noted. In some the rib was bilateral; in others, on the right or the left side only.

The abnormality occurred more often on the right side than the left. Furthermore it was observed that bilateral cervical ribs, although sometimes equal in length, were usually unequal, the rib on one side being obviously larger or longer than its counterpart. The right cervical rib was the larger more often than the left, when bilateral cervical ribs were present. This right-sided preponderence was noted by Schneider, who detected 18 bilateral, 13 right, and 9 left, in a total of 40 cases of cervical rib.

Of 325 cases found in Natal and the North-Western Cape, detailed information of race and sex was recorded in 222 only.

The anatomical distribution of cervical rib (all cases —325) is shown in Table I, and by race and sex (222 cases) in Table II. The percentage of cases of cervical rib in the people X-rayed is shown in Table III by race and sex.

TABLE I. CERVICAL RIB, ANATOMICAL DISTRIBUTION

Right side only	102	176	54·1%
Bilateral—right greater than left	74		
Bilateral—equal	42		13·0%
Bilateral—left greater than right	39	107	32·9%
Left side only	68		

TABLE II. CERVICAL RIB, ANATOMICAL DISTRIBUTION BY RACE AND SEX

Race	*Right only*		*Bilateral*						*Left only*	
			Right greater than left		*Equal*		*Left greater than right*			
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
European	1	5	4	5	6	2	—	3	3	6
Coloured	15	30	11	15	5	5	7	7	9	25
Asiatic	1	—	—	4	—	—	1	1	—	2
Native	19	2	7	1	5	2	5	1	6	1

Whereas more cases were found in females than in males of the European, Coloured and Indian races, there is a very definite reversal in Natives, where male to female was 0·61% : 0·13%.

TABLE III. DISTRIBUTION OF CERVICAL RIB BY RACE AND SEX

Race	Male			Female			Both Sexes		
	Cervical rib	*No. X-rayed*	%	*Cervical rib*	*No. X-rayed*	%	*Cervical rib*	*No. X-rayed*	%
European	14	5,335	0·26	21	4,399	0·47	35	9,734	0·37
Coloured	47	11,857	0·39	82	12,441	0·65	129	24,298	0·54
Indian	2	649	0·31	7	554	1·26	9	1,203	0·74
Native	42	6,817	0·61	7	5,664	0·13	49	12,481	0·41
TOTALS	105	24,658	0·42	117	23,058	0·51	222	47,716	0·46

SUMMARY

1. In 67,716 persons of both sexes and all races 325 cases (0·46%) of cervical rib were found by mass-miniature radiography.

2. 52·3% of cases were unilateral and 47·7% bilateral.

3. More unilateral ribs occurred on the right side than on the left—102 compared with 68.

4. In 155 cases of bilateral rib, only 42 were equal in length. Of the remainder, the right rib was longer than the left in 74 cases, and the left longer than the right in 39 cases.

5. Except in Natives, more cases occurred in females than in males.

I thank the Secretary for Health for permission to publish this paper, and Dr. B. A. Dormer, to whom I am indebted for his teaching of observation in medicine, for his advice.

REFERENCES

1. Schneider, J. (1954): S. Afr. Med. J., **28,** 689.
2. Crimm, P. D. (1952): Amer. J. Roentgenol., **68,** 241.

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

ADDRESS ON INAUGURATION OF S.A. REGIONAL COUNCIL*

C. D. READ, F.R.C.S., F.R.A.C.P. & S., P.R.C.O.G.

President

It is my very great privilege as President of the Royal College of Obstetricians and Gynaecologists to inaugurate the new South African Regional Council of the College. By this South Africa takes its place with Canada, Australia and New Zealand in its relation with the parent body, and I can assure all present that the mother will be proud of its newborn child, and hopes that the child will always be affectionately disposed towards its mother.

It would be remiss of me if I did not express thanks to those of you who, for years, have acted on the South African Reference Committee, and so paved the way to the formation of this first Regional Council, freely elected from among your Fellows and Members. To those ladies and gentlemen in Cape Town, Durban, Johannesburg and Pretoria we extend our most sincere thanks for the work they have done, for the time they have so unselfishly given without thought of personal gain, but with the one object in view—that of improving the services of obstetrics and gynaecology in your country, and indeed in the world generally. It would be almost invidious to mention names, but I cannot refrain from acknowledging the thanks of us all to Professor Crichton, Professor Gordon Grant, Colonel Impey, Professor Black and Dr. Standing in the early formative days of the Reference Committee, and latterly the influence of Professor James Louw, Professor Heyns and Professor te Groen in addition. To these, and to all the others, we owe a very great debt of gratitude, and on behalf of my Council I extend to them our thanks.

When we speak of a College, the word generally conjures up in our minds a picture of some building. Usually we think of bricks and mortar, or of some of the lovely colleges of Oxford and Cambridge, or even of some more modern but none the less beautiful buildings which adorn some of our cities. These of course constitute only the home of the College, for the College itself is not materialistic, but spiritual, and consists of a number of individuals banded together for a common purpose.

Broadly speaking, our common purpose is the advancement of obstetrics and gynaecology, and I should like you all to realize that this is a living College, striving all the time to attain this end. Naturally the effort of the College as a whole is dependent entirely on the individual efforts and accomplishments of its Fellows and Members, and its influence for good is dependent on these. We are a completely non-political body, and will always remain so. We elect our Executive Council by free vote of the Fellows and Members, regionally represented, just as in your Regional Council you elect yours. I want you always to remember that your interests are our interests, that your aims are our aims, and that the fuller you flourish the better pleased we shall be. We realize your difficulties in that you are relatively sparsely populated and have long distances separating you. We appreciate these difficulties and your overcoming them makes us admire you all the more. I think I can say that the helping hand will be available at all times, but I would point out to you that in large measure you are the arbiter of your own affairs. Matters of policy, of course, such as adequacy of training facilities, suitability of training posts etc. must be centrally directed, but we regard you as our advisers even in these matters, and in large measure the influence of the College for good will, in South Africa, be dependent on you.

It is a particular pleasure for me to be with you all today—especially so as I feel I am one of you. Having graduated in New Zealand I am a Dominion man, and the ties between the country of my birth and South Africa are very strong, having been cemented by two world wars. While I am the first Dominion man to have had the honour of election as President of the Royal College of Obstetricians and Gynaecologists I feel sure I shall not be the last—such is the democratic nature of our Constitution. I feel that others from the Commonwealth in the future will follow me—why not a South African?

THE AIMS OF THE COLLEGE

When the College was founded its aims and objects were recorded in the memorandum to its articles of association. The important one, the one which crystalizes the main reasons for its foundation reads:

> 'To encourage the study and improve the practice of obstetrics and gynaecology, subjects which should be inseparably interwoven'.

For long our branch of medicine has been one leg of the tripod of medicine. It was laid down in the second Medical Act that every candidate for admission to the Medical Register shall be instructed and examined in Medicine, Surgery and Midwifery.

Moreover these are the three clinical subjects to which chairs

* Durban, 4 July 1956.

were allotted in our universities. In spite of this, all was not well. To lay down this equality in an Act of Parliament is one thing, to implement it is another. On the General Medical Council and on the various teaching bodies it was only natural that the great corporations had a preponderance of representation, and it was difficult for the obstetrician and gynaecologist to obtain what he considered to be his fair share of the student's time, and facilities for teaching and examining.

It was only when the teachers of obstetrics and gynaecology combined in the Royal College of Obstetricians and Gynaecologists that they were able to make a united effort and to obtain reasonable teaching, training and examination facilities. It was the poor teaching in the past, the emphasis laid upon the moment of birth to the exclusion of all the important parts of obstetric training, which made the full scope of our subject incomprehensible to those who were deprived of further postgraduate study. It is our duty to see that the rising generation is not brought up in such a state of misunderstanding.

BASIC TRAINING

To encourage the study and improve the practice of obstetrics and gynaecology necessitates sound basic training of the student, which, in most centres, is now given. It means also sound postgraduate training for those who intend to devote their professional life to obstetrics and gynaecology. From the first, the College has emphasized training rather than mere examination, and no candidate is allowed to sit for the examination who has not held resident appointments for minimum periods in medicine, surgery, obstetrics and gynaecology, in hospitals recognized by the College as capable of training consultants. More than this, however, is necessary. If our branch is healthy it must grow and develop, and this depends to a large extent upon the type we admit to our Membership.

In Great Britain there has developed a great enthusiasm for the whole-time professor, on the assumption that only a whole-time man has time to teach and to do research work. Whether this experiment will succeed or not, time alone will show. In the past British obstetrics and gynaecology developed its own school, advanced along its own lines, and increased our knowledge in the theoretical and scientific aspects as well as in the clinical.

From the time of Smellie to the present day, advances have been made, a little bit here, a little bit there. Someone makes a suggestion, others criticize and modify it, and finally another small step is made. Spectacular advances like those of Simpson in discovering the anaesthetic effect of chloroform, of Lister in discovering how to combat sepsis, or of Fleming in discovering penicillin, are rare. By far the greater part of our steady advance is made in small steps, by men whose names are not remembered except in the general way that in their time they were leaders in their own locality. Every teaching school worth its salt has many of these stored in local traditions.

These are the men who, bringing to bear their store of clinical experience, tempered and restrained by scientific knowledge, with which they have found time to keep abreast, have produced the steady advance in scientific knowledge and clinical treatment.

Note that of the three great discoveries I mentioned two, viz. anaesthesia and antisepsis, without which modern surgery could not have developed, were the gift of clinicians. Those engaged in clinical research will be the first to acknowledge the help and guidance they have received from the pure scientist, the anatomist, the physiologist, the pathologist, the bacteriologist. It is this combination of the clinician with the scientist which has given us our steady advances, and it remains to be seen whether the whole-time clinician, without the incentive of private practice, will do more than the busy clinician did, so stimulated and so interested in his patients, that he wanted still more to know 'how the wheels went round'.

THE HOSPITAL STAFF

Whether or not the whole-time professor produces much good work does not affect the duty and responsibility of the other members of the hospital staff. No man has a right to accept an appointment on the staff of a hospital unless he is prepared to devote time to the furtherance of knowledge, and no man on the staff of a hospital is doing his full duty as a teacher unless he develops his critical faculties, is dissatisfied with the present, and is constantly aiming at something better. This means that in all directions he must be abreast of the times and, in some directions, ahead of his colleagues.

If his clinical experience or experiments give him some advance, however small, it is his duty to record it in print, to inform others interested in the subject, and to receive their corrective criticisms. Too often we have the spectacle of men immersed in clinical work, recognized locally as masters, but whose influence on the advancement of the profession they love is negligible outside their own narrow circle, because they will not be bothered to record their experience or stand the rough-and-tumble of public criticism and debate.

To encourage the study and improve the practice of obstetrics and gynaecology, this College does all in its power to stimulate the spirit of research in its Members. The Fellowship was initiated as an encouragement to research and, although in practice we more frequently raise to this degree those who have attained a certain position by their clinical or teaching ability, nevertheless a good piece of research work is always recognized by early elevation to this degree.

Each year we award Lectureships limited to Members or to Fellows of not more than two years' standing. The College inherits a considerable sum of money for the purpose of encouraging research work in obstetrics and gynaecology. The income from this will be awarded to men doing research work, and I hope that some of these research scholarships will be awarded to Dominion Members—all are eligible.

A young man elected to the staff of a hospital enters into a priceless heritage. Junior appointments are not usually overburdened with clinical woris. There is considerable leisure, which he can devote to research, to following through the laboratory each specimen he removes, comparing it with others in the literature, discussing the subject with the pathologist, the physiologist or other scientist, endeavouring in some direction to advance a little further our knowledge of our subject. Or, on the other hand, he may endeavour to translate his good fortune into terms of cash by using his position merely as a means to acquire a lucrative practice. The former develops his critical faculties and, even if he makes no epoch-making discovery, lays a solid foundation of mental and clinical training upon which to build his future practice and reputation; while the latter becomes a mere vendor of goods, little removed mentally from the apple woman with her street barrow. Let us remember we have a duty to our profession, a duty to our College, a duty to humanity, to endeavour, each to the best of his ability, to leave our knowledge a little further advanced than we found it.

THE UNION OF OBSTETRICS AND GYNAECOLOGY

The statement of the main reason for the foundation of the College 'To encourage the study and improve the teaching of obstetrics and gynaecology' continues: 'Subjects which should be inseparably interwoven'. Those of us who have spent our lives in the practice and teaching of obstetrics and gynaecology know how impossible it is to separate the two. We know that the subject, to be understood by the student, must be taught as a whole—anatomy, physiology, abnormal physiology, pathology. Obstetrics comes chiefly in the section of physiology. A few, a very few, argue that they can be taught separately, but even these do not agree upon the line of cleavage. Forty years ago there was a movement in Great Britain to separate the two, and four Universities went so far as to appoint a Professor of Obstetrics and an independent Lecturer in Gynaecology; and this was one of the main reasons for the establishment of our College. What made the danger so acute was the fact that this separation was in reality part of a movement to make gynaecology, and what was called surgical obstetrics, a part of general surgery, and to divorce it completely from obstetrics. It was soon recognized in these schools that the division was an artificial one and led to confusion in the students' minds and, at the next election, in each instance, the subjects were reunited.

Today in Great Britain there is not a single school in which the teaching is divided and, I think I am correct in saying, in only two schools throughout the Empire. Even in these schools the division is only a question of degree, since those who desire separate teachers insist that the teacher of gynaecology must also be a trained obstetrician. But, although through the influence of the College in binding together all teachers of obstetrics and gynaecology this division has been practically eliminated from our teaching schools, it will soon again rear its head if we are not constantly vigilant, and it behoves you, the younger generation, to preserve your heritage.

This desire to separate them arises from ignorance of the true scope of obstetrics and gynaecology.

We cannot blame practitioners of the older generation for this ignorance, which is due to the way the subject was taught until comparatively recent times. The clinical training in obstetrics consisted originally in the collection of signatures to certify that we had been present when a certain number of babies entered the world. No antenatal training, no insistence upon attendance during the first stage; no emphasis upon the abnormal and the importance of its early recognition; nothing but a number of certificates collected with the mentality of a boy acquiring postage stamps. Clinical gynaecology consisted largely in watching the performance of a number of operations, with a few perfunctory demonstrations in methods of examination; but, as in those days our ability to perform a pelvic examination was not tested in the final examination, I fear little attention was given to it.

Can it be wondered at, that medical men, trained in that period and without subsequent clinical training in the subject, considered the obstetrician to be little more than a beneficent attendant at an act of nature which an all-seeing providence terminates in its own good time, provided that the attendant has the necessary patience to leave nature unassisted; while gynaecology consisted in the surgical removal of organs provided by providence for this purpose. No realization of the training and experience required in making a decision when to interfere, or of the skill necessary to make that interference successful. No realization of the number of patients with gynaecological ailments who are cured by other means than operation or, if an operation is required, that conservatism must be emphasized in all other than malignant conditions. This general ignorance of our work is due to the old methods of teaching.

Now, united, we have been able to obtain a reasonable amount of the students' time, with full facilities for teaching and for examination. Only the full realization, by the whole profession, of the extent and importance of our branch of medicine will extinguish these attempts to absorb us into other organizations. If the rising generation shows the same abysmal ignorance as mine, that is the fault of the teachers, and in the future that is your responsibility. Having obtained these facilities, it is your duty to see that full use is made of them and that they are not whittled away.

THE COLLEGE IN THE DOMINIONS

When the College was founded it was acclaimed not only throughout the British Isles but in all the Dominions. Its development was much quicker than its sponsors in their moments of wildest optimism had dared to hope, which is merely a proof of the great need of such a College to bind together the obstetricians and gynaecologists. One of the earlier of the Dominions to realize its import and send forth candidates in considerable numbers was South Africa. Up to the present time Fellows and Members in a Dominion have the same privileges and responsibilities as the Fellows and Members in the UK, but being so far away from the centre, and themselves unable to serve on the Council, and to help to guide the destinies of the College, they cannot be expected to take the same personal interest in its development. Moreover, each Dominion has its own problems—problems which cannot be fully understood by the Central Council. We therefore decided upon this new venture.

In the British Isles and in each Dominion the number of men devoting their lives to the practice of obstetrics and gynaecology alone must always be fewer than those in general medicine or in general surgery. If we separate, Great Britain and each Dominion forming its own College, we have less likelihood of getting what we know to be necessary for teaching and practice. 'Unity is strength', and therefore we hope that all will adhere to the parent body. Realizing, however, that South Africa has its own problems and that something more is required to stimulate unity, this Royal College has established a South African Regional Council which will have autonomy in purely South African matters. This Council will consist of elected members, representing both Fellows and Members, and it is your duty to nominate and to vote for those who will best represent your views, and we hope that it will be the ambition of every Fellow and Member to serve on the Council. This Council must be a success, and it is entirely in your hands to make it such.

What we want to emphasize is this. This new Council is neither Cape Town, Pretoria, Johannesburg nor Durban. It belongs to East London, Port Elizabeth, Pietermaritzburg, Bloemfontein and any other centre where Fellows and Members reside, as much as to any of the other great centres, and I do ask you to keep its outlook a national one.

Now for one word of warning. You will realize that the South African Regional Council can be given authority only upon matters which relate to South Africa alone. Resolutions which affect our Fellows and Members elsewhere must be ratified by the Central Council. Any other method will lead to chaos. It means, however, that at times both sides must show patience and forbearance, and at times some delay may be inevitable. Differentiation between local and general matters will not always be easyl, but an attempt to understand the other point of view will always clear away difficulties.

I conclude by reiterating that your destinies are largely in your own hands. We wish you luck, success and happiness. We have little doubt that you will attain all.

I have very much pleasure in proclaiming the new South African Regional Council duly inaugurated.

Super ardua consurgamus, floreat collegium

A PHANTASY

S. LEVIN, M.B. (RAND.), M.R.C.P. (EDIN.), D.C.H.
Johannesburg

'Wot ye not that such a man as I can certainly divine?' (Gen. 44 : 15).

ADVANCES IN TREATMENT, 1966 : RESPIRATORY INFECTIONS

As early as 10 years ago practitioners were well aware that respiratory infections accounted for well over 90% of all infectious disease seen in practice. Today this vast unclassified group accounts for almost 100% of the minute amount of infectious disease still seen in the western world. With the recent introduction of multi-superimmunization techniques, virostatics, bactericidals and parasiticides, there are virtually no other infections that have not been conquered. Respiratory infection itself has now dropped to negligible proportions in the western world, and medical schools are having difficulty in finding cases for demonstration to students, most early infections having already been 'nipped in the bud' by the use of BGX.

Mucoviscidosis

The brilliant work at Los Angeles culminated in the epoch-making paper of Bloch[1] on β globulin X (BGX). In truth it may be said that the road to his discovery was paved through the way of paediatrics—in the paper by Anderson[2] on the subject of what used to be called fibrocystic disease of the pancreas. The emphasis in this disease later shifted to the lungs: mucoviscidosis was the magic term that wrought a revolution in thought on respiratory infection. It was then realized that emphasis should be shifted away from the infecting agent, and that the 'soil' should be studied instead. What was it, in the nasal, the pharyngeal, the bronchial mucosa, that permitted micro-organisms to enter and thrive? It was soon found that the respiratory secretion was abnormal, and that perhaps all types of respiratory infection was based on this chemico-pathological anomaly. In 1954 Geddes[3] hazarded the view that bronchiectasis was a congenital disorder due to a localized nidus or a generalized area of lack of normal bronchial secretion. Six years later the daring experiments in Peiping[4] demonstrated the truth of this hypothesis both in bron-

chiectasis and also in tuberculosis. However, of the numerous studies on bronchial pathology and chemistry, that of Thomas[5] in Boston is pre-eminent. Since his qualitative analysis of bronchial mucosal biopsies and secretions on 489 individuals with various respiratory diseases and 162 controls, the way was open for Southam[5] in Alabama to demonstrate that the lack of β globulin X (BGX) in epithelial secretions was the factor responsible for the occurrence of respiratory infections.

BETA-GLOBULIN X (BGX)

Purified the same year and synthesized by Ethichem laboratories in 1961, it became available for large-scale trials in America and in England. The results were dramatic. It has been hailed as the greatest advance in replacement therapy since insulin. Using it as a 1% aerosol inhalant Crackers[7] reported on 81 patients with serious respiratory infections—all cured in a matter of hours. He also used bactericidins and virostatics, but showed clearly that the results were better than could be obtained by the use of these alone. Engelhoff and Van Goon[8] followed with an account of the value of BGX in coughs, colds and 'flu, and in the same year the Medical Research Council of Great Britain published its controlled studies[9] on 304 patients with respiratory infections treated with BGX plus VSBCC (Virostatic-Bactericidin Compound, Biopharm labs.) and 109 treated with VSBCC alone. The earlier rate of improvement in the former group was stated to be statistically significant—indeed very much so—and it was hailed (albeit cautiously) as a great advance in the therapeutic armamentarium of this modern age.

In Tokio, Kutisaki's work amply confirmed the English results,[10] and dispelled the pessimistic doubts of Shoenholler *et al.*[11] Further, its value as a prophylactic in all forms of undifferentiated respiratory infection has been noted by many workers[12–15] and has been stressed by Cherbakov[16] who showed that the exhibition of BGX does not interfere with the local mucosal production of antibodies in the presence of asymptomatic infection.

Diagnosis and Selection of Cases

Patterson and his group,[17] in London, counsel caution in BGX therapy. They feel that the irresponsible and frivolous prescription of BGX for minor respiratory infections is unwarrented and that care should be exercised in its use. Findlay[18] has decried the tendency to high concentrations of BGX and has reported toxicity in the form of severe nausea in 4 patients who swallowed large quantities of aerosol. Bergstrom[19] insists that BGX should not be exhibited unless there is a definite indication for its use, a point also made—with rather more vehemance—by Brailsford.[20] They feel that a diagnosis of bronchial mucosal BGX lack should first be established, and that BGX should not be used indiscriminately. They both point out that with modern anaesthesia, bronchoscopy by a competent chest physician is completely safe, and examination of bronchial secretion by chemical means and by Mamanicolaou's technique will either confirm or vitiate a diagnosis of congenital aglobulinic mucosis. While ben Yussef[21] concurrs with Bergstrom, he points out two factors that must be kept in mind:

(*a*) One bronchial aspiration is not sufficient for diagnosis. A lack of BGX at one examination occurs not uncommonly—for reasons yet obscure. Repeated examinations must be performed in order to distinguish permanent from temporary hypo- or aglobulinic mucosis.

(*b*) Aspirations must be performed separately from all accessible bronchi, as the aglobulinic area may be quite small and localized.

There does appear to be some evidence to substantiate Patterson's views on the injudicious use of BGX. Belanger's report[22] appears to demonstrate that the constant use of aerosol can decrease or even completely stop the normal production of BGX in the bronchial mucosa.

Weisberger *et al*[23] are at present engaged on spectrophoretic analyses of plasma BGX levels, which they feel may do away with the need for bronchoscopy, but as Kowalski[24] of the Institute of Chest Physicians points out—the plasma BGX level is not necessarily an index of bronchial mucosal BGX level. Kowalski has in fact stressed that bronchial smear examination is insufficient, and that a diagnosis of aglobulinic mucosis can only be made by bronchial biopsy. While Rogers[25] agrees with this view he feels that the danger of haemorrhage after biopsy is too great to warrant this procedure as a routine. He points out that bronchoscopy with aspiration of secretion is sufficient in the large majority of cases, and Zsst's controlled study[26] on this subject would appear to give a correlation of 91·6% accuracy between bronchial aspiration and biopsy.

Roux[27] has since demonstrated a small number of patients whose infections are not significantly improved by BGX. He theorizes that BGX is not one substance, but a whole conglomeration of protective globulins, and that some patients are lacking a separate factor which he calls BGX_2. Larner's preliminary report[28] lends credence to Roux's theory, and seems to open up a whole new vista—reminiscent of the multitudes of vitamins.

Smadding[29] classifies respiratory infections under 3 headings:

1. Infections in a normal respiratory tract.
2. Infections in a respiratory tract partially lacking mucosal BGX.
3. Infections in a congenitally aglobulinic mucosa.

He suggests that in cases in group 1, therapy should be limited to a VSBC compound. All patients known to be in group 3 should have daily prophylactic aerosol BGX. He regards this as replacement therapy in aglobulinic mucosis—in the same manner that insulin is replacement therapy in diabetes. If a respiratory infection should supervene—and its incidence should be negligible if prophylaxis is regular and adequate—treatment should be as in group 1—with VSBCC. Recovery can be expected in a few hours. In group 2, BGX need not be used as a prophylactic measure, but should any symptoms occur which might conceivably be due to respiratory infection, BGX and VSBCC should be given early and energetically.

Disappearance of Respiratory Infection

Respiratory infection is finally disappearing because of scientific treatment directed toward two goals: (*a*) Destruction or immobilization of the infecting agent, and (*b*) augmentation or replacement of defective 'respiratory mucosal infection-resisting β globulin X'. The problems thus facing medical science have become crystallized. The main unsolved enigmas are still accidents—cancer, cardio-vascular-renal disease, rheumatism, neuroses psychoses and mental deficiency, skin diseases and allergic disorders.

SUMMARY

An account is given of the work leading to the discovery of the protein fraction lacking in the respiratory mucosa of people suffering from respiratory infections.

It is felt that BGX should be used prophylactically as replacement therapy in aglogulinic mucosis.

In hypoglobulinic mucosis BGX should not be used unless an infection is known to have supervened, when it can be given at the same time as VSBCC.

Examination of bronchoscopic washings is almost as useful as biopsy in establishing a diagnosis of aglobulinic mucosis.

REFERENCES

(*Owing to lack of space the reference list will be published in our next issue*, 31 *April* 1967.—*Editor.*)

UNION DEPARTMENT OF HEALTH BULLETIN

Union Department of Health Bulletin. Report for the 7 days ended 12 July 1956.

Plague, Smallpox, Typhus Fever: Nil.

Epidemic Diseases in Other Countries:

Plague: Nil.

Cholera in Calcutta (India); Chittagong (Pakistan).

Smallpox in Kabul (Afghanistan); Rangoon (Burma); Phnom-Penh (Cambodia); Ahmedabad, Allahabad, Bombay, Calcutta, Cuddalore, Delhi, Jodhpur, Kanpur, Karikal, Lucknow, Pondicherry, Tuticorin (India); Dacca, Karachi (Pakistan); Tourane (Viêt-Nam).

Typhus Fever in Kabul (Afghanistan); Alexandria, Cairo (Egypt).

IN DEFENCE OF DOCTORS*

There is a savour of age against youth in the accusations by a senior member of the medical profession that moral and ethical standards among students and young doctors have fallen. As reported in the *Cape Times* on Wednesday, a branch president of the Medical Association in his farewell address harshly criticized the standards of the rising generation in his profession and cited a number of specific instances of dishonesty and moral irresponsibility. Such citing of instances, however, is no more than stating the truism that there are black sheep in medicine as there are in every other profession. Professor M. van den Ende, who as Dean of the Medical Faculty at the University of Cape Town has had considerable experience of students and young doctors, has since given it as his opinion that the people studying medicine today are every bit as good as those of more than 20 years ago when he was a student.

The picture presented by the branch president undoubtedly gives an exaggerated impression. If it were not so the Medical Council, with its high sense of the profession's responsibility to the public, would immediately set investigations afoot. That it is willing to do so when complaints are made was shown by an incident that occurred in the Transvaal a few days ago. Residents of Harzenbergfontein smallholdings, near Jackson's Drift, made the accusation that a boy lost his life through carbon monoxide poisoning because of the refusal of doctors to give immediate help. The Council is to consider the complaint, and if it finds that a *prima facie* case has been made, a public inquiry will be held. There are, therefore, powerful safeguards; furthermore it is possible to assure the public that standards in the medical profession in South Africa are exceptionally high and have long compared favourably with those of other countries.

At the same time it is a good thing that misgivings about the coming generation of doctors should be given an airing, for new problems beset the complete training of medical men and women. Partly they are world problems; the disappearance of the old-time family doctor with his sense of service and his intimate and sympathetic understanding of the family as a group, and the growth of specialization which encourages, particularly where the specialist has never worked as a general practitioner, a certain non-human remoteness between doctor and patient. Partly they are problems peculiar to South Africa; for instance whether the present atmosphere of our society may be encouraging an attitude of indifference towards the mass of the people, the Natives, which will spread to a general callousness towards individuals as human beings. A very wise physician of another century once defined his task as to cure sometimes, to relieve often and to comfort always. It will be a tragedy if our medical men of the future come to think only in terms of cure, and to neglect the character-searching job of giving relief and giving comfort.

* *Cape Times* editorial, 20 July 1956. By kind permission.

THE PROFESSIONAL PROVIDENT SOCIETY OF SOUTH AFRICA

The Chairman's report presented at the Annual General Meeting of the Professional Provident Society of South Africa, which was held at Medical House, Johannesburg, on 21 May 1956, reflects the very remarkable growth of this organization, which was established about 15 years ago for the benefit of members of the Medical and Dental Associations of South Africa, and subsequently reorganized to include members of the Pharmaceutical Society and the Bar Council.

According to its balance sheet, the assets of the Society at the end of 1955 totalled £143,000, but by the time of the meeting they had passed the £160,000 mark. The income of the Society in 1955, derived from subscriptions and interest on investments, exceeded £46,000, which was £12,000 more than for the previous year. After meeting sick-pay claims and administration costs, which aggregated less than 10% of the total income, the Society was able to credit the individual members' apportionment-accounts with approximately £37,500 in dividends and £4,500 in interest. The credits in dividends were on the basis of 2s. 8·85d. per share per month, which means that the cost of sick-pay cover to those members paying 2s. 9d., 2s. 10d. and even 3s. 0d. per share per month was negligible. The amount of sick pay to which a member holding the maximum of 50 shares is entitled exceeds £125 per month. The figures show that virtually the total subscriptions paid, particularly by members who because of their age at entry pay the lower subscription rates, are being credited to mersemb' apportionment-accounts (on which the Society pays interest at the average rate received on its invested funds), thus ensuring a considerable amount to be withdrawn on retirement from practice or from the Society on reaching the age of 63.

The total membership of the Society is now about 730 which, when compared with the total membership of about 8,500 of the various member organizations, would suggest that most of the members of these organizations are still unaware of the considerable benefits offered by the Society The very decided advantage of some measure of security in the event of illness as well as the compulsory saving towards retirement are well worth considering. Details of membership may be obtained from the Secretary, Professional Provident Society of South Africa, P.O. Box 6268, Johannesburg (Telephone 23-1560).

PASSING EVENTS : IN DIE VERBYGAAN

Dr. D. A. H. du Toit, ginekoloog en verloskundige, van Groote Kerk-gebou 816, Kaapstad, het van huisadres verander. Hy is nou woonagtig te Berg-en-See, Comrieweg, Kampsbaai, telefoon 3-98019. Die adres en telefoonnommer van sy spreekkamers bly onveranderd.

* * *

Supplementary Health Services Bill. A Select Committee on this Bill reported to the House of Assembly on 25 May 1956 that 'After careful consideration of the written and verbal representations submitted to it, your Committee has come to the conclusion that it will be impracticable under present circumstances to make legislative provision in one Bill which would adequately serve the divergent interests of the various groups performing supplementary health services'. The Select Committee accordingly recommend that the Bill be not proceeded with.

* * *

The South African Paediatric Association. The next meeting of the Cape Town sub-group of this Association will be held at 8·15 p.m. on Friday, 3 August 1956, in the E-Floor Lecture Theatre, Groote Schuur Hospital, Cape Town. An address will be given by Dr. R. B. Watson on Genito-Urinary Problems in Infants and Children.

REVIEWS OF BOOKS : BOEKRESENSIES

PORPHYRINS AND PORPHYRIA

Porphyrins. By A. Vannotti. (P. 258, with illustrations. 50s.) London: Hilger & Watts Ltd. 1954.

Contents: 1. Physico-Chemical Characteristics of Porphyrins. 2. Methods of Extraction and Qualitative and Quantitative Determination of Porphyrins. 3. Porphyrins in Nature. 4. Physiological Metabolism of Porphyrins in Man. 5. Changes in Porphyrin Metabolism in Human Pathology. 6. Biological Action in Porphyrins. 7. Porphyria. 8. Treatment of Porphyrin Disease. Bibliographies. Index.

In view of the considerable frequency with which porphyria is encountered in the Union of South Africa, any major publication on this subject is most welcome.

Professor Vannotti's name is well-known in this field, his original monograph 'Porphyrine and porphyrinkrankheiten' having appeared in 1937. This present edition, which was translated and revised by Professor Runnington, was completed in 1952 and presents much new material. Unfortunately, publication was delayed and as a result certain major advances have not been included. Nevertheless, this volume is a most acceptable addition to the literature on porphyrin metabolism and porphyria.

The first chapter deals with the physico-chemical aspects of porphyrins and includes a section on the fluorescence spectra. This is followed by a cursory review of the methods of extraction and qualitative and quantitative determination of porphyrin. Following a brief but good account of the porphyrins in nature, considerable space is devoted to the physiological and pathological aspects of porphyrin metabolism in man. In particular the author draws on his clinical experience in describing the various conditions in which porphyrin excretion is abnormal, e.g. gastro-intestinal disorders, anaemia, etc.

To the clinician the section on porphyria is the most interesting. Professor Vannotti's experience extends to 56 cases. The various classifications that have been used are listed. A good account of the symptoms and signs of the various types of porphyria follows, but the familial nature of the disease is insufficiently emphasized and some observers in this country have very little doubt that the cutanea tarda form and the acute abdominal and nervous types are merely different expressions of the same basic disorder. The reviewer cannot agree that the 'presence of porphobilinogen in idiopathic porphyria could be conducive to the appearance of severe cutaneous lesions' (page 192). The term 'mixed porphyria' is better abandoned if it is used to indicate a mixture of congenital porphyria and acute idiopathic porphyria.

Insufficient emphasis is placed on the very great diagnostic importance of the recognition of porphobilinogen in acute porphyria. The chapter on treatment is poor and uncritical. The variability in the course of porphyria is notorious and hence it is surprising that Professor Vannotti has placed so much faith in vitamin therapy.

To all who are interested in porphyrin metabolism and porphyria this book is particularly valuable in its extensive survey of the continental literature.

L.E.

RENAL FUNCTION

Reflections on Renal Function. By James R. Robinson, M.D., Ph.D. (Cantab.). (Pp. 163. 17s. 6d.) Oxford: Blackwell Scientific Publications. 1954.

Contents: 1. Introduction. 2. Glomerular Filtration and Tubular Reabsorption. 3. Tubular Secretion. 4. The Excretion of Water and Sodium. 5. Renal Control of Acid Base Balance. 6. The Regulation of Renal Function. 7. The Regulation of the Volume of the Body Fluids. 8. Epilogue. References.

As Dr. Robinson says in the preface: 'Renal function is controversial, and perhaps ought to be more so'.

In the compass of this little book, which is not intended to be a comprehensive review of the very considerable literature of renal physiology, he gives a clear and succinct account of much of the working of the kidneys, but at the same time, in his reflections on certain controversial and unsolved problems of renal function (especially those at the cellular level), he emphasizes his special interests, and in addition reveals the incompleteness of our present knowledge. He is meticulous, moreover, in his presentation of varying viewpoints on certain phenomena, e.g. 'the Oxford shunt'.

The first chapter comprises a brief but good exposition of the clearance concept in relationship to glomerular filtration rate and a short account of tubular reabsorption. The section on tubular secretion takes us into the realms of cellular physiology, but in the succeeding account on the excretion of sodium and water much that is 'unconventional' is discussed, including the 'counter-current hypothesis' to account for the production of a hypertonic urine. The same holds for the chapter on the regulation of the volume of body fluids, while the regulation of the acid/base balance is relaively straightforward.

This stimulattng book is strongly recommended to advanced students of physiology and anyone who is about to enter the realms of reneal risearch.

L.E.

HANDBOOK ON SYNTHETIC DRUGS

Synthetic Drugs. A Handbook for Chemists, Physicians and Pharmacists. By H. Ronald Fleck, M.Sc., F.R.I.C., F.R.M.S. Pp. 380 + viii. 70s. 0d. London: Cleaver-Hume Press Ltd. 1955.

Contents: 1. Amoebacides. 2. Anaesthetics. 3. Analgesics and Antipyretics. 4. Antibiotics. 5. Anti-Convulsants. 6. The Anti-Histaminic Drugs. 7. Anti-Malarials. 8. Anti-Tuberculous Drugs. 9. Autonomic Drugs. 10. Cardiac Drugs. 11. The Hormones. 12. Hypnotics and Sedatives. 13. Muscular Relaxants and Hypotensive Drugs. 14. The Sulphonamide Drugs. 15. Vitamins. 16. Supplement. General Index. Clinical Index.

The author has set out to provide a book which will be of value to physicians, pharmacists and chemists, from the point of view of collation of the synthetic, analytical and clinical aspects of synthetic drugs. Structural formulae are provided abundantly; this may be of value to the organic chemist, but it is doubtful whether doctors and pharmacists in general will derive much pleasure from the sight of long chemical names and the illustration by chemical formulae of the structure of drugs and their changes during reactions. The 3½ pages on thyroxine deal with the synthesis and clinical production of this hormone; the statement that only one pure hormone has been isolated from the thyroid gland is incorrect.

Official drugs should serve the needs of practically all prescribers. However, since attempts are being made all the time to force new drugs on doctors, chemical names must be understood so that their relationship to previously used drugs can be detected; in this way worthless or potentially harmful drugs can be avoided. For those—all too many—who are keen on 'experimenting' with the latest pharmaceutical compounds a book such as this should be at hand so that the clinical trial can at least be on a proper chemical basis. Since the range of available drugs is very great only representative types are presented in this book. On a number of drugs, therefore, information is not available. The classification is unsatisfactory, as for instance in the chapter on Cardiac Drugs where the following compounds are arranged and considered: Group I. Cardiovascular—Khellin, Pronestyl, Leptayol, Nikethamide, Amyl Nitrite. Group II. Anticoagulants: Dicoumarol, Tromexan. Group III. Diuretics: Mercurophylline, Mersalyl, and Thiomerin. From the point of view of the physician there are a number of features that detract from the value of the book.

N.S.

OCCUPATIONAL HEALTH

Bulletin of the World Health Organization. Pp. 742, with illustrations. 10s. Geneve: The World Health Organization. 1955.

Contents: Introduction. Pre-employment and periodical health examinations, job analysis and placement of workers—Sven Forssman. L'absentéisme—Sven Forssman. Sickness absenteeism—G. J. Fortuin. Mental health and group tensions—J. Koekebakker. La santé mentale dans Lindustrie—Thomas M. Ling. Outlines of a concept of industrial psychiatry—Erland Mindus. The health problems of old workers—Lord Amulree. Physical working capacity of old workers and physiological background for work tests and work evaluations—E. Hohwü Christensen. The employment of elderly persons—T. A. Lloyd Davies. Le travailleur âgé: Problème médico-social—René Sand. Réadaptation des travailleurs physiquement diminués—Pierre Houssa. Industry's contribution in the field of rehabilitation—A. R. Thompson. Le facteur humain des accidents du travail dans l'industrie—Agostino Gemelli. Facteurs humains en sécurité des travailleurs—J. Godard. Industrial health services in large plants—G. E. C. Burger. Organization of health care in small plants in the USA—Seward E. Miller. A national industrial health service on a voluntary basis—Haakon Natvig. Occupational health problems: summary of discussions at the Leyden and Milan seminars. Problèmes de médecine du travail: résumé des discussions aux seminaires de Leyde et de Milan.

This collection of papers, presented by authors from various countries at WHO seminars on occupational health held at Leyden (Holland) and Milan (Italy), is most instructive and indicates the extent to which occupational health services are developing in the United States of America and certain European countries. To us in South Africa, where a very marked increase in secondary industry has occurred, certain papers, such as that by Dr. S. E. Miller on 'The Organization of Health Care in Small Plants in the U.S.A.', are of particular moment and might possibly serve as a basis on which our own service might be built.

It is of some interest to note that the consensus of opinion was against the view that periodical medical examination should play a great part in occupational health schemes, and was satisfied that the mental-health aspects, which have up to now received scant recognition in such schemes, will in future fully repay further investigation and application.

As it is impossible with justice to review satisfactorily all these interesting papers, it cannot be too strongly recommended that their careful study by industrial medical officers and other interested parties will be fully rewarded.

E.D.C.

CARDIOVASCULAR DISORDERS ON PHYSIOLOGICAL PRINCIPLES

Cardiac Diagnosis. A Physiological Approach. By Robert F. Rushmer, M.D. Pp. 447 + viii, with illustrations. South African price £4 17s. 9d. Philadelphia & London: W. B. Saunders Company. 1955.

Contents: Part I. Function of the Normal Cardiovascular System. 1. Functional Anatomy of Cardiac Contraction. 2. Functional Characteristics of the Systemic Circulation. 3. Circulatory Response to Arising. 4. Functional Characteristics of the Pulmonary Circulation. *Part II. Regulation of the Cardiovascular System.* 5. Principles of Peripheral Vascular Control. 6. Regulation of Cardiac Output. 7. The Factors which Determine Stroke Volume. *Part III. Congestive Heart Failure.* 8. The Cardiac Reserve. 9. The Etiology of Congestive Failure. *Part IV. Methods of Cardiac Diagnosis.* 10. The Measurement of Pressure. 11. The Size and Configuration of the Heart. 12. The Estimation of Cardiac Output. 13. Heart Sounds and Murmurs. 14. Electrocardiographic Interpretation: Abnormalities of Rate, Conduction and Rhythm. 15. Electrocardiographic Interpretation: Changes in Configuration of the Complexes. *Part V. Diagnosis of Cardiac Disease.* 16. Myocardial Ischemia. 17. Myocarditis. 18. Valvular Disease. 19. Congenital Heart Disease. 20. Possible Heart Disease.

This book differs from the usual text-book in attempting to explain the symptoms and signs of cardiovascular disorders strictly on physiological principles. It is divided into 5 main sections.

The first is concerned with the function and normal anatomy of the cardiovascular system. The way each of the two ventricular chambers is constructed and adapted to its own functional requirements as a pump is excellently outlined. The peripheral vascular system in both circulations and the reflexes associated with maintenance of pressure and flow are described at rest, with change of posture and on exercise.

The second is the most valuable in the book. Here the peripheral blood flow and cardiac output are discussed. Cardiac output depends not only on stroke volume and heart rate but also on ventricular distensibility and contractility. The significance of ventricular relaxation and the physical factors involved are dealt with at length, as well as the part played by the residual volume in increasing output.

The third section deals with the physiology of congestive failure, avoiding controversial issues. The symptoms produced by this condition are attributed to the disordered physiology which results.

In part 4, the technical and clinical methods used in diagnosis are discussed. In a volume of this nature only an outline can be given of radiology and electrocardiography and the degree of accuracy that can be expected from these forms of investigation is examined. Cardiac catheterization and ballistocardiography are briefly mentioned. The physics behind some of the special instruments required, such as electromanometers, are summarized. The technical methods are well described, but not so the clinical methods used in examination, such as auscultation. It is a pity, in a work of this kind, to find that the importance of normal and abnormal ventricular asynchrony is completely omitted and hence the heart sounds are quite inadequately described.

In the last chapter a brief outline is given of cardiac ischaemia, myocarditis, valvular disease of the heart and congenital heart disease. The physiological principles previously outlined are applied.

This book can be recommended strongly, to students and practitioners alike, for the physiological content. The clinical side, however, does not quite live up to the promise made by the early chapters on normal function. Throughout the diagrams are excellent and the references, though mainly American, are up to date.

V.S.

DRUG THERAPY

1955-56 *Year Book of Drug Therapy.* Edited by Harry Beckman, M.D. Pp. 560. $6.00 post paid. Chicago: The Year Book Publishers Inc. 1956.

Contents: Introduction. Allergy. Antibiotics and Sulfonamides. Cardiovascular Diseases. Dermatology. Endocrinology. Gastroenterology. Hematology. Internal Medicine. Neuropsychiatry. Obstetrics and Gynaecology. Ophthalmology. Otorhinolaryngology. Pediatrics. Surgery. Venereology.

In this volume there are abstracts of articles from journals received between August 1954 and August 1955. Once again one must refer to the fine quality of this series of publications, the numerous tables and illustrations, and the useful index of authors as well as the index of subjects, which helps one to trace a forgotten article. The abstracts cover a wide variety of articles, many of which have appeared in journals not readily accessible to most readers. The editorial notes on many of the articles are interesting and critical. Some of them might be taken up by the interested reader as the starting point for a piece of research. Answers to a number of problems are provided in many of the abstracts: the choice of anti-infective or steroidal agent for certain conditions, the side-effects that have been produced by newer drugs, the type of patient in whom side-effects may occur, the methods by which untoward effects may be avoided or treated. About anticonvulsant drugs that may affect the blood-forming organs the quotation is given that 'any patient failing to report for blood examinations should be compelled to give up medication'. The section dealing with anticoagulants is prefaced by answers to a list of questions on their use in myocardial infarction. Among interesting sections indicative of recent advances in special fields is that dealing with tranquillizing drugs. All who prescribe or dispense drugs will find much interesting material in this book.

N.S.

SURGERY OF THE AMBULATORY PATIENT

Surgery of the Ambulatory Patient. Third Edition. By L. Kraeer Ferguson, M.D., F.A.C.S. with a Section on Fractures by Louis Kaplan, M.D., F.A.C.S.

This book, which was reviewed in the *Journal* of 16 June 1956 (**30,** 578) is published in London and the Commonwealth market by Pitman Medical Publishing Co. Ltd., London under agreement with J. B. Lippincott Company, Philadelphia and Montreal.

SQUINT

Rehabilitation of A Child's Eyes: Second Edition. By Richard G. Scobee, B.A., M.D., F.A.C.S., Revised by Herbert M. Katzin, M.D., F.A.C.S. Pp. 133. Illustrated. $2·85. St. Louis, U.S.A: C.V. Mosby Company. 1955.

Contents: Part I. Orientation. Chapter 1. The Effect of Crossed Eyes on the Personality. Chapter 2. General Information. Chapter 3. The Teamwork of the Two Eyes. Chapter 4. How the Eyes Focus. Chapter 5. Why Eyes Cross. Chapter 6. The Bad Effects of Crossed Eyes. Part II. Rehabilitation of Squint. Chapter 7. Glasses in the Treatment of Crossed Eyes. Chapter 8. Treatment of Amblyopia Ex-anopsia the 'Lazy Eye'. Chapter 9. Eye Exercises. Chapter 10. Operations in the Treatment of Crossed Eyes. Chapter 11. The Treatment of Crossed Eyes After an Operation. Glossary.

When looking at the title of this little book 'Rehabilitation of a Child's Eyes' one is not quite sure what to expect. Actually it deals with the squinting child. The second edition is edited by Dr. Herbert Katzin of New York. Apparently it was well received and popular in America, where the first edition was reprinted in 1950 and 1952.

The author states in his foreword that the book was primarily written for parents of children with 'crossed' eyes. Parents are naturally upset and worried over the condition and many questions arise in their minds. Practically all the questions they could possibly ask are answered in the various sections.

The chapter on the 'effect of crossed eyes on personality' is true to life, and one agrees with all that is said. The author puts in a plea for early operation in all cases, before the age of 6 years. He goes on to explain why eyes cross, when treatment should begin, what is involved in treatment, how the ophthalmologist proceeds, the role of the orthoptist, the role of the parent, and when surgery is necessary.

In the chapter on 'Teamwork of the Eyes' coordination of the eyes, convergence and divergence, fusion, depth perception are discussed.

The author succeeds in covering the whole subject of squint in an easy and understandable way. The book is well and simply written, and an intelligent lay person will have little difficulty in

following what is being explained in the various chapters. Use is made of simple but excellent diagrams to illustrate the various conditions and terms under discussion.

Although it is not written for the advanced student, one feels that medical students will grasp the subject of squint much better by first reading this little book before studying the subject in the more advanced text-books on ophthalmology, for it always proves to be a difficult one.

The only statement with which one does not agree is that all astigmatism is lenticular in origin.

A useful glossary is to be found at the end of the book.

J.K.deK.

CORRESPONDENCE : BRIEWERUBRIEK

DR. MOSTERT'S VALEDICTORY ADDRESS

To the Editor: I have received and read the Secretary's Letter of June 1956 containing Dr. G. van R. Mostert's valedictory address. I want to congratulate Dr. Mostert, who I hope is in better health now, on the views he has expressed in his address, so plainly without exaggeration.

I am of the considered opinion that this address is of such importance that it should not have been hidden in the Secretary's Letter, but printed in the *Journal* alongside the many valedictory addresses of the past.

I fail to comprehend why 'the opinions expressed in it (that is, in the Secretary's Letter) should be kept confidential to members as far as possible', firstly because we have nothing to hide and secondly because they affect not only the whole of the medical profession but also the public!

I feel that the above thoughts and reasonings will be shared by the majority of older practitioners, who as Dr. Mostert stated, 'must have sensed this growing instability in our minds, manifested by an absence of the little courtesies we once knew and the presence of petty acts of spite and malice springing from a brash and ill-mannered rising generation'.

Nathan Finn

27/30 C.N.A. Building
East London
14 July 1956

THE NEWSLETTER

To the Editor: So the Newsletter issued by the Association has proved a failure with the first issue! Those of us who were naive enough to think that every doctor could be trusted with confidential information have been proved to be wrong. The *Rand Daily Mail* of 18 July splashed on its main page and on its posters, with the boldest headlines, the criticism levelled against a few doctors by the immediate past-President of the Northern Transvaal Branch of the Medical Association of South Africa.

It has become traditional for the President's valedictory address to deal with some aspect of the social, economic or medico-political problems confronting our profession. Dr. Mostert chose to deal with a difficult subject—that of selection of medical students. He presented a picture, arising out of his experience as an ex-Inspector of Interns, that caused him a great deal of worry and anxiety about the future. Presidential addresses are not subject to discussion and the address was accepted with the usual recommendation that it be published in the *Journal*.

Just at that time the profession was very agitated about the publication in the *Journal* and in the daily press of the New Year message of the Chairman of Federal Council, in which the profession was accused of becoming mercenary. Our Branch Council was worried about the ease with which such articles were taken over by the press, published usually out of their context, and always without the necessary knowledge of the background. In view of the anticipated (now proved) reaction of the press, the Branch felt that if Dr. Mostert's address was circulated privately in the form of a Newsletter for the sole information of members of the medical profession, and not in the regular issue of the *Journal*, the press would not have access to it.

Unfortunately some doctor with a standard of ethics and morality no better than that of the 'opium pedlar' mentioned by Dr. Mostert, has seen fit to hand his confidential document to the press. The inevitable sensational handling of the matter has followed.

Dr. Mostert made a plea for improved methods in the selection of medical students. To back up his plea he quoted a few examples of doctors with whom the profession could well dispense. There was no wholesale condemnation of doctors as the blazing headline of the *Rand Daily Mail* suggests.

I should like to conclude by repeating what I said on my assumption of office, that 'whilst I cannot dispute Dr. Mostert's facts about medical students or doctors, I disagree with him fundamentally on his basic assumptions that the present day medico—embryo or full-fledged—is any worse than his forbears'.

Ben Epstein
President, Northern Transvaal Branch, Medical Association of South Africa

104 Van Riebeek Medical Buildings
Schoeman Street
Pretoria
19 July 1956

P.S. These views represent my own personal opinion and have not been submitted for approval to my Branch Council.

A CALL FOR AN ENQUIRY

To the Editor: I am writing in connection with a front-page article which appeared in the *Rand Daily Mail* of 18 July under the heading, 'A Doctor Accuses'.

The doctor is a retiring president of one of the Branches of our Association and he makes the following accusations:

1. That unnecessary Caesarian operations are being performed to 'harvest a higher fee'.

2. That it is 'common knowledge' that students have participated in the sale of opium.

3. That 'our authorities' frown at delinquent tendencies and then adopt the tactics of the ostrich and proceed to forget them—he quotes as an example the case of a student who was found guilty of organized thefts and yet proceeded to qualify.

Another even more serious allegation is made that a young doctor surrounded himself with aged drug-addicts and then was able to 'put on the screw' and boast openly of his 'nightly pethidine round'. He also deplores the fact that the medical schools which are the centres which should remedy these defects are so difficult to influence, and he warns any would-be reformer that he is in for much disillusionment—'I say this after having knocked at so many doors myself without effect'.

In spite of these statements he concludes that the moral standard of medicine is still very high.

If this doctor has been correctly reported he has revealed a most alarming state of affairs which, I submit, we as a profession cannot treat with apathy. If medical students are known to be selling opium, and if doctors are known to exist who 'put on the screw' to pethidine addicts and boast about their nightly pethidine rounds, they should go to prison as drug pedlars.

These statements, following closely, as they do, on Dr. Sichel's more general strictures, must demand our earnest attention.

These accusations have now been made common knowledge by the *Rand Daily Mail* and I am writing to urge that our Association insist that a searching enquiry into these statements be made by the Medical Council and, if they are proved, that action be taken, not only against the students who sell opium but also against those in authority to whom this is 'common knowledge' and who have overlooked this criminal activity.

The vast majority of the profession that I have met since I came to South Africa 8 years ago are men of conscience and integrity, and a doctor still commands respect by virtue of his calling apart from any personal attributes he may have, but this state of affairs cannot continue if we allow statements such as this to go uninvestigated and, if proved, ignored. If these accusations are ill-founded, or if the doctor has been misquoted, it is vital to our standing as a profession that the facts be made known. If the accusations are proved, then the doctor who made the statements reported in the

Rand Daily Mail will have done a great service, not only to the profession of Medicine, but also to the public of South Africa.

J. C. Gilroy

924 Philadelphia Corner
Jeppe Street
Johannesburg
18 July 1956

DIFFICULTIES OF SELECTION

To the Editor: I had originally intended to send this letter to the Secretary of the Association, since it is in reply to Dr. G. van R. Mostert's address which was published in his newsletter. As the matter has received so much publicity in the press it is perhaps better to reply through the *Journal*.

Before commenting on individual points let me suggest that it is a characteristic of men of an older generation to comment adversely on the young, and that right through history each generation has gazed on its progeny with dismay and concern. Let me also point out that George Bernard Shaw many years ago in 'The Doctor's Dilemma' pointed out the very faults in his generation of doctors that Dr. Mostert now sees in mine.

Let me also point to one of Paul de Kruif's books, in which he comments adversely on the doctors of the USA at the turn of the century, when they expressed disappointment at the introduction of public-health practices to stamp out typhoid fever—for they had sent their sons to college on the proceeds of the treatment of a then common illness.

The fact that careers in all professions, including medicine, are being opened to all groups in the population and not confined to the sons of the professional classes is merely a symptom of the growth of economic as well as political democracy. It increases the resources of the nation and brings in fresh blood. Medicine would be all the poorer if some of its most illustrious men had been excluded because of choosing the wrong father.

Dr. Mostert's allegations about its being common knowledge that medical students sell opium is one which I personally refuse to believe. It is possible that individuals have been guilty of criminal acts—but to condemn all medical students in such terms is, I feel, not in the best interests of the public or the profession.

His concern with the commercialization of the profession is misdirected. This is the reaction of the profession to the society in which it lives. Private enterprise is the order of the day and the doctor's fees depend on the type of work he does. Operations command good fees and, as Shaw pointed out about his generation of Victorian doctors, it is wrong that a clinical decision should be associated with a difference in fees. It must, even when the strictest clinical judgment is used, subconsciously influence the doctor's decision.

Dr. Mostert quotes Dr. Sutherland, Professor of Anatomy at Melbourne University, to castigate him. But what he says is true: 'There are no tests of infallible predictable value'. As the late Dr. T. B. Davie pointed out at a lecture in Cape Town, many of the tests are empirical and the results depend too much on who carries them out. In any case, in any type of scientific measurement one wants to know what one is measuring. For instance, what measurements tell who will be a good general practitioner, who a public health administrator, who an anatomy lecturer, who a neuro-surgeon, who a clinical teacher, who a pathologist, and so on. Especially today the practice of medicine is so diversified that one set of qualities cannot furnish the requirements of all the branches.

What are our criteria of integrity—apart from financial honesty? Integrity depends on the ethics and morals of our society. The Calvinist, the Humanist, the Socialist and the Catholic all have their own criteria of these values and it is best to allow natural selection to apply. No system of selection at present available would be any better or more acceptable than the present one.

I feel that the answer lies in our roles as citizens of the country in which we live. If there are values or practices of which we disapprove and which reflect themselves in our profession, let us try to build a better society and in so doing we shall improve the standard of our profession.

A. A. Zabow

309 Voortrekker Road
Maitland
Cape
20 July 1956

MEDICAL SERVICES AND MEDICAL ETHICS

To the Editor: I have read with interest and pleasure Mr. Maynard Page's letter[1] in your issue of 23 June. I have not met Mr. Page, but I think I should like to, since he is obviously one who loves an argument. To someone like myself who regards arguments as one of the condiments of life, this would be a great attraction; moreover, his reference to 'the Pobble without any toes' suggests a refreshing erudition of the right kind.

Mr. Page has done pretty well with the ammunition at his disposal; but it is not very explosive. May I present the reverse argument by suggesting a few lines of thought. Mr. Page sets down three headings for his argument:

A. *Medical Aid Societies*

Here Mr. Page is like a man climbing a hill of loose sand. I cannot believe that he is unfamiliar with the back-cloth against which the performance of Medical Aid work must be seen. The system was designed to help people of low and medium income to insure against the cost of serious and prolonged illness. The medical profession happily cooperated to the extent that they agreed to treat such patients at fees less than those usually charged to private patients—about 2/3rds. But if such a concession is to be made it is surely reasonable for those who make it to insist that it should not be abused; for this is what some Medical Aid Societies are doing. We cannot see any justification for the inclusion in a Medical Aid Society of persons of liberal means if the services they receive are to be supplied at reduced rates. In parallel, we see no harm in a rich man insuring himself against the cost of illness, but in such a case the doctor feels entitled to recover his normal private fee. It is not fair to expect a reduction simply because one is insured. So that it is reasonable for Tom, Dick, Brown and Jones to insure against the cost of sickness (and at a preferential fee), for they are in the lower income group, and reasonable too, for Harry and Robinson to join them if they are in the same income group but, we think, quite improper if they are well-to-do persons.

On the question of the closed panel it has long been the view of our profession that a patient should be allowed to choose his own doctor, and *vice versa* that a doctor should be able to decline to accept a patient for treatment (other than an emergency) for reasons which he may think good and sufficient. Hence our objection to the closed panel, in which there is a relative or absolute restriction of choice of doctor by patient, and usually an absolute requirement that a doctor shall treat a patient allotted to him, whether he wishes to do so or not.

B. *Levying of fees from private patients for radiological services*

Let me say that the Transvaal Provincial Administration are not the only offenders. The operative catch-phrase here is 'farming out'—a revolting expression which offends me so much that whenever I hear it my gorge rises (please, Mr. Page, do not ask me what a gorge is). Suffice to say that the Medical Council—not the Medical Association—has decided that the practice is unethical *vis-à-vis* a doctor. If it is unethical for a doctor to 'farm out' then, we feel, it is unethical for the Transvaal Provincial Administration, or anyone else, to do likewise in respect of medical services. The other point in this connection is of course the allegation that the Transvaal Provincial Administration (and other bodies) are entering into direct competition with private radiologists. Viewing this with the detachment of an unaffected observer, it would seem that there is some justification for this allegation, but I have no doubt that a radiologist could argue the point more fluently.

C. *Discount granted by the S.A.I.M.R.*

Here there is another operative word—'dichotomy'—(a word used hideously and incorrectly to describe the division of a fee between someone who has earned it and someone who has not). Originally, I understand, it was applied to the division of a fee in such a way that some part of it could be described as a 'rake-off', and I think everyone would agree that such a thing would be deplorable. I would say the intention behind the Medical Council's forbidding of 'dichotomy' is that when a patient pays a fee for medical services, that fee—and all of it—should go to the doctor providing the service. If some part of it goes to a second party

then it is 'dichotomy', and the implication is that the patient has paid some portion of his fee for services not rendered. He has thus (incidentally) been overcharged. So it seems, Mr. Page, we are on common ground here.

The rule is also possibly designed to prevent a doctor from coming to an arrangement with, say, a consultant whereby he agrees to refer cases for consultation in consideration of a monetary payment—though it is sad to think that the contemplation of such a state of affairs should be necessary.

Perhaps you will agree that the picture of a professional organization offering discounts is an undignified one, holding out the horrid prospect of such things as 'free gifts', and 'blood sedimentation rate carried out free to patients requiring a full blood-count'. Really, one must draw a line somewhere, and the sooner this line is drawn the better.

I do not feel qualified to dispute Mr. Page's legal pronouncements, but would make two points. The first is that the two extracts quoted by him from the Medical, Dental and Pharmacy Act, refer to 'persons', and that the S.A.I.M.R. is not a 'person', but a corporate body, and the question is whether such a *body* can be held responsible for the same acts of omission and commission, the same sins and pecadilloes, as a medically qualified person. The second is that the S.A.I.M.R. does, apparently, practise for gain—else how could their full-time employees be paid? So, Mr. Page, I wonder if the *absurdum* is really so absurd after all?

One thing I would like to say. *Of course* the medical profession is concerned about any development which would tend to reduce the income of doctors. I can see nothing either surprising or regrettable about this. I would suggest that since pre-war days the cost of medical attention has increased in a smaller proportion than that of any other important commodity. Speaking for myself, my 'specialist' consultation fee is the same as that charged by my predecessor before the war, and my operating fees have risen by not more than 50% in the same period. No doctor, I am perfectly certain, regards as 'unethical' any change in the *status quo* which would be to his financial disadvantage; but he is entitled to fight changes which he regards as 'unethical' and which, at the same time, operate to his financial disadvantage—and if Mr. Page has the impression that the only unethical practices disputed are those with financial allusions then attendance at almost any meeting of the Federal Council would dispel that illusion.

I have written at some length because Mr. Page's letter constitutes a criticism of the way in which the Federal Council is dealing with some of the problems before it, and because there may be some members of the Association who, reading Mr. Page's letter, may feel a loss of confidence in the Federal Council. I hope what I have said may allay any such qualms.

Lucas Young

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Church Street
Pietermaritzburg
5 July 1956

1. Page, S. M. (1956): S. Afr. Med. J., **30**, 602.

TETANUS

The following letter has been addressed to the Hon. Secretary of the Cape Western Branch of the Medicol Association of South Africa:

In view of the increasing number of cases of tetanus occurring throughout South Africa, my Committee feels strongly that the Medical Association should investigate the matter, and report on the advisability of recommending to the Ministry of Health, Union Government, that *compulsory active immunization* be undertaken during the first year of life.

Tetanus is certainly a bigger killer than smallpox in this country. The whole question of the administration of anti-tetanus serum to patients with injuries bristles with difficulties—both in its indications and in its administration.

We feel it is high time something drastic was done in this important sphere, and it is hoped that the Cape Western Branch will take this up as a matter of urgency.

My committee have studied and herewith sincerely acknowledge Dr. R. Slome's article[1] in the *South African Medical Journal* of 5 June 1954.

M. Meyerowitz
Hon. Secretary, Medical Committee, Woodstock Hospital

Woodstock Hospital
Cape Town
16 July 1956

1. Slome, R. (1954): S. Afr. Med. J., **28**, 473.

PROPOSED SOUTH AFRICAN ORGANIZATION FOR COMBATING RHEUMATISM

To the Editor: I have today received a letter from Robert M. Stecher, M.D., of Cleveland, Ohio, USA, who is on his way to South Africa, where he is expected about 10 September, to deliver lectures in several towns.

As President of the *Ligue Internationale contre le Rheumatisme*, of which organization I am a member of many years standing, Dr. Stecher writes: 'I am disappointed to see that our organization has no representation on your Continent. It seems to me that the Union of South Africa would be a proper place to start, and I am appealing to you for advice and help in this project. . . . You already know, of course, that the next meeting will be held at Toronto in June 1957, a meeting at which I shall preside. In view of the fact that I am about to visit South Africa it seems to me that it is proper for me to raise the question whether rheumatologists or the doctors of internal medicine in your country might not band themselves together in one organization devoted to the study and care of rheumatic patients and rheumatic diseases, and then apply for membership'.

The news about the Toronto meeting[1] you published on 14 July.

Personally I suggested such an organization for South Africa many years ago in papers published in our *Journal*, but there was no response. In a paper published on 25 December 1937 'Some practical aspects of Diagnosis and Treatment of Rheumatism'[2] I said: 'In conclusion I should like to draw your attention to the social and economic importance of the so-called rheumatic diseases and arthritis in particular . . . this has been recognized some time ago in different countries and I can see no reason why we, in South Africa, could not or should not start a campaign following Great Britain'. In my paper 'Rheumatic Disease'[3] published on 23 July 1938, which received full editorial support[4] in our *Journal* and was also printed by the *Acta rheumatologica*, the official Journal of the International League against Rheumatism, then at Amsterdam, Holland, I stated: 'It would be fitting for South Africa to be a working member of the Empire Rheumatism Council, because all other Dominions have started already on anti-rheumatic campaigns'.

Several other papers, and also my evidence before the National Health Services Commission under Dr. Gluckman, have stressed the importance of the rheumatic diseases in South Africa, but not even the war organizations of health services for our fighting forces and industrial workers have taken any notice of it.

I need not stress the prevalence of the rheumatic group of diseases all over South Africa. The time is long overdue for a national organization to be started. I trust that that this visit by so eminent a missionary as Dr. Stecher will bring about the desired result.

Because I am now in East London, having asked for my name to be removed from the specialist register, and hence no longer a member of the Physicians' Group, I must request you, Sir, to give publicity to this letter. I hope that it will be possible to start such an organization even before Dr. Stecher arrives, or at least for those actually interested to consider the matter in order to discuss it with Dr. Stecher in September.

I therefore appeal to the Association of Physicians of South Africa and its sub-groups to discuss this matter urgently.

Nathan Finn

27-30 C.N.A. Building
East London
17 July 1956

1. Passing Events (1956): S. Afr. Med. J., **30**, 668.
2. Finn, N. (1937): *Ibid.*, **11**, 878.
3. *Idem* (1938): *Ibid.*, **12**, 487.
4. Editorial (1938): *Ibid.*, **12**, 485.